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## The context of recovery: Individual experiences of recovery from work-related trauma

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Running head: Recovery from Work-Related Trauma

The Context of Recovery: Individual Experiences of Recovery from Work-Related Trauma

Sally Edmondson

A Thesis Submitted as a Partial Requirement for the Degree of Master of Psychology at  
Edith Cowan University

Date: 6 July 2001

*Declaration*

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### Abstract

In this study the recovery experiences of individuals with posttraumatic stress disorder (PTSD) due to a work-related trauma was investigated. The aim of the study was to explore individual experiences within an ecological framework in order to develop a clearer understanding of the significance of contextual factors. The study utilised a multiple case methodology and data was analysed using the qualitative method of focused conceptual development. Participants were four males and one female ranging in age from 37 to 57 years and two female key informants who had four and seven years of experience of working with stress claims in the worker's compensation system. Participants were interviewed about their experiences of recovery. The data was triangulated with archival data from the participant's vocational rehabilitation file and information provided by the key informants. Findings suggest that viewing work-related trauma within an ecological framework enhance our understanding of the trauma recovery process. This study revealed a number of key influences in participant's experience of recovery, such as the influence of the worker's compensation system, social support and coping style. These included issues such as recognition and legitimacy of psychological injury and the type of services offered in the system. Implications for clinical practice and the wider community are discussed including the importance of a comprehensive ecological assessment when working with work-related trauma victims.

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Most of all, thank you Sam, for everything, for waiting, for endless patience and believing in me when I didn’t. You leave me speechless. I dedicate this project to you.

Dedication

*To Sam, for rocking horses....*

*It matters not how straight the gate,  
How charged with punishments the scroll,  
I am the master of my fate:  
I am the captain of my soul.*

*- W.E. HENLEY*

## Table of Contents

	Page
Chapter One	
Introduction .....	1
Overview.....	1
Work-related Trauma.....	2
Chapter Two	
Literature Review.....	4
Ecological Factors.....	4
Social Support.....	7
Cognitive Appraisal.....	9
Coping Style.....	14
Physical and Psychological Versus Psychological Injury.....	16
Psychological Growth.....	18
A Theoretical Framework. For Understanding Recovery.....	21
Research Questions.....	23
Chapter Three	
Method.....	25
Methodological Issues.....	25
Multiple Case Design.....	26
Participants.....	27
Materials.....	28
Procedure.....	28
Chapter Four	
Data Analysis.....	30
Findings.....	31
Key Informant: Jane.....	32
Key Informant: Beth.....	36
Primary Participant: Simon.....	40
Primary Participant: Mark.....	45
Primary Participant: Luke.....	52
Primary Participant: Paul.....	58
Primary Participant: Mary.....	66
Chapter Five	
Discussion .....	71
The Influence of the Worker's Compensation System.....	72
Legitimacy.....	73
Control.....	73
Social Support Systems.....	73
Employer Support.....	74



Family Support.....	74
Friends.....	75
Co-Workers.....	75
Professional Support.....	75
Vocational Rehabilitation.....	76
The Individual’s Personal Systems.....	77
Active Coping style.....	77
Passive Coping Style.....	78
Interaction of Personal Resources and The Recovery Environment.....	79
Physical/Psychological Versus Psychological Trauma.....	80
Psychological Injury.....	80
Physical/Psychological Injury.....	80
 Chapter Six	
Implications.....	82
Limitations and Directions for Future Research.....	83
References.....	85
Appendix A.....	90
Appendix B.....	94
Appendix C.....	96
Appendix D.....	97

## Chapter One

### Overview

There is a substantial body of literature regarding the prediction, development of symptoms and treatment of Posttraumatic Stress Disorder (PTSD) (e.g., Basoglu et al., 1994; Foa & Meadows, 1997; McIvor & Turner, 1995; Solomon, 1999). The two main areas of focus in the literature have been prediction of PTSD and treatment efficacy. Predictive studies have investigated a variety of factors such as victim and event characteristics in an attempt to discern which factors are significant for individuals who develop PTSD and individuals who do not (e.g., Basoglu et al.; Blanchard et al., 1996). The second area of focus has been an evaluation of the effectiveness of clinical interventions such as exposure, desensitisation, psychotherapy and cognitive-behavioural therapy (e.g., Foa & Meadows; Shalev, Bonne & Eth, 1996).

Understanding the factors that predict the development of PTSD is an important area of psychological research. However, these factors do not necessarily predict the course of recovery, nor do they illuminate facilitating or hindering factors within this process (Harrison & Kinner, 1998). Moreover, predictive studies focus on deficits, absence and rates of clinically significant symptoms. This does not contribute to understanding positive adjustment, adaptive coping or the significance of positive support from those surrounding the individual and other systems within their recovery environment.

An ecological perspective on recovery from PTSD goes beyond the symptom reduction, time-frames and treatment of PTSD discussed in the literature. There is little research focusing directly on the total recovery experiences of traumatised individuals. Scurfield (1985) noted that the psycho-social context in which a survivor lives is often overlooked. An individual's recovery is entwined with the social, familial and other environmental factors surrounding them (Harvey, 1996; Scurfield). An ecological view of recovery from psychological trauma recognises that recovery does not occur in a vacuum but is subject to a variety of complex and interacting factors.

Individuals recover from traumatic experiences in different ways and at different rates. A number of studies have attempted to identify factors that will distinguish those

who recover faster. However, there has been little research on what is subjectively important, in particular, what individuals who have recovered believe was important or unhelpful to them in overcoming trauma (Harrison & Kinner, 1998). This may prove to be of particular importance considering that Harrison and Kinner found that the individual's perception of social support was more important than actual measures of social support received in a study of psychological distress following armed robbery. Therefore, exploring the individual's perception of helpfulness and unhelpfulness during their recovery seems of particular importance. The aim of this research is to explore individual experiences of recovery from work-related trauma within an ecological framework.

Individuals who experience a trauma must come to terms with it within the context of their particular situation. The recovery environment is unique to each person. Their experience of recovery will be affected by their geographic location, financial status, social resources, and the individual's coping strategies. There are a number of factors that may help or hinder an individual's overall recovery. Such issues as social support network, religion and amount of medical attention may all influence a person's ability to overcome a traumatic experience (Calhoun & Tedeschi, 1998; Orford, 1992).

### Work-Related Trauma

Individuals who experience a trauma at work are a challenging population for mental health professionals. As the trauma occurs in the workplace, the individual's recovery is uniquely influenced by the contextual factors of their workplace. These include organisational dynamics, the employer, coworkers and involvement in the worker's compensation system. The worker's compensation system is complex and the legislation is state specific in Australia. For further information on Western Australia's worker's compensation system please see (WorkCover, 2000). Under the worker's compensation system a worker who undergoes a traumatic work accident or injury or is present during a robbery may be entitled to compensation, vocational rehabilitation and access to medical and psychological care. However, the legislation also requires the individual to take a measure of responsibility for their own recovery. The worker must

attend medical appointments, participate in vocational rehabilitation and, if possible, attempt to return to work.

Harrison and Kinner (1998) noted that the incidence of armed robberies has risen dramatically in western populations since the 1960s, as has the brutality of the attacks. Despite the alarming growth in armed robberies, there is little agreement as to the nature and extent of the impact these events have on victims. With workplace violence on the increase it is more and more likely that mental health professionals will treat work-related trauma victims on a regular basis (Kiem, 1999). Therefore, it is imperative that clinicians have a clear understanding of the impact of trauma and the possible influence of the individual's environment on their recovery. In order to understand the impact and importance of context within the recovery process, the perspective of individuals who have suffered from PTSD is essential. Viewing recovery within a contextual framework aids psychologists and others by increasing the number of potential resources at their disposal. The therapist can encourage the individual to maximise the natural support resources that are most helpful in the individual's recovery environment and minimise any barriers to their recovery.

## Chapter Two

### Literature Review

Although the literature directly dealing with recovery from work-related trauma is scarce, an ecological framework for trauma recovery suggests a complex interaction between a wide variety of personal internal factors, events and environmental factors (Orford, 1992). A review of current literature suggests a number of areas to explore. On the whole, research has focused on discrete areas of interest. Few studies have attempted to investigate the multifaceted nature of trauma recovery. In the following section an ecological perspective will be developed by examining ecological factors, social support, cognitive appraisal, coping style, physical and psychological versus physical injury and psychological growth.

#### Ecological Factors

Trauma recovery will depend on the social environment in which it takes place, different people will experience the same event differently and each individual's recovery environment is unique. It appears, however, that the importance of the recovery environment has received limited attention in the literature (Green, Wilson & Lindy, 1985). Harvey (1996) stated that the focus of clinicians' understanding has been on the pre-traumatic characteristics of the victim and the duration of the victim's exposure to the traumatic stimulus. However, she suggested that the way in which the individual interprets the trauma and the influence of the larger environment surrounding the person during their recovery are of equal importance.

Harvey (1996) also noted that the current psychological literature does not emphasise the importance of environmental factors in the process of trauma recovery. Some authors (e.g., Bradford, 1999; Flannery, 1990; Shalev et al., 1996) cite the importance of various environmental factors in recovery. However, they do not explore more than one factor in any depth or as occurring within the individual's unique social and functional system. Some researchers of trauma acknowledge the importance of environmental factors. Yet, once noted environmental factors are often ignored.

Environmental factors that have been suggested as influences in the recovery process include social support (Lyons, 1991) and financial security, in particular, whether the individual is financially secure enough to continue in pre-injury roles (Bradford, 1999). It has also been suggested that support groups may be beneficial, particularly in strengthening social support (Bradford). It appears that in a time when social support is critical, victims often withdraw, choose to move homes, communities and seek new employment (Seymour, 1997). The American Academy of Pediatrics Task Force on Adolescent Assault Victim Needs [AAPTFAAVN] (1996) focused on the impact of trauma on the adolescent population. In discussing the recovery environment they suggest it is important for health workers to encourage building the protective '*shields*' of family and community systems around a trauma victim as a pivotal treatment goal.

Within the trauma literature there are a number of proposed models of recovery. These models vary from those who focus primarily on individual characteristics to those who focus on social support. Taken together, they provide valuable material for the development of an interpersonal systems framework of recovery.

Green et al. (1985) viewed recovery from trauma at an individual level. They conceptualise recovery through a model that focuses on individual processing of the event. Recovery from trauma is a dynamic process in which the individual's processing of the event is affected by long standing characteristics of the individual and characteristics of the individual's recovery environment. They suggest that if the recovery environment is favorable, the process of trauma integration will occur in a natural non-pathological manner and as a result the individual reaches an adaptive functional state. If the recovery environment is not favorable the individual may develop a form of psychopathology and require assistance in dealing with symptoms.

Green et al. (1985) suggested a number of contextual factors that they believe are important aspects of the recovery environment. They state that social support research has so far shown that more supportive environments are associated with a better adjustment to stressful situations. However, they note that having social support available is different from accessing support.

Other factors besides social support have been less well conceptualised and studied in the trauma recovery literature (Green et al., 1985), in particular, the impact of

differing cultural characteristics on the individual. The attitude of the society within which the individual operates is an important factor that has not received significant attention in the literature. Green et al. (1985) reported that there are a number of ways in which the environment works as a system to protect the victim. They report that people close to the traumatised individual tended to surround the individual to protect them from further situations or people that may cause further trauma. They called this phenomenon '*the trauma membrane*' and note that in order to break into the membrane to assist the individual an outsider needs to be screened and perceived as being ultimately helpful before being allowed to proceed.

Earlier work by Figley (1985) also views recovery as a process but places even greater emphasis on the individual's role in recovery. He stated that in the aftermath of trauma the human response is both common and predictable. Figley conceptualises the process of trauma recovery as the individual transforming from a victim to a survivor. He explains the difference between these two roles as follows; the survivor is not rendered stationary by the trauma and draws upon the experience as a source of strength whereas the victim is immobilised by the experience. Further, he stated the recovery process is about "*making peace*" with the memories of the trauma. This provides a somewhat vague definition of recovery as resilience. It may not be necessary for an individual who has experienced trauma to draw upon the experience as a source of strength to be able to function effectively. This definition may be viewed as saying those who recover function and those who do not recover do not function effectively. Thus, this does not clearly define what the recovery process is but rather describes the possible outcomes of the experience.

Figley (1985) suggested a model for recovery from trauma, that proposes that individuals pass through five stages through which they change from victims to survivors. The phases constituting the model are catastrophe, relief and confusion, avoidance, reconsideration and adjustment. Although he places them in a sequential order he notes that individuals can regress back through the various stages. This model allows for the chronic nature of PTSD by suggesting that individuals may pass back and forth throughout the stages before reaching adjustment. However, the phases appear loosely defined and no explanation of the formulation of the stages was provided.

Environmental factors have a large influence at the time of the trauma (Figley, 1985). The person-environment transaction that occurs post-trauma determines the level to which an individual is able to have a sense of control and avoid a sense of helplessness. He stated that the importance of environmental factors cannot be over emphasised. Viewing the individual's experiences from an ecological perspective is useful when exploring Figley's concept of recovery. It enables a closer analysis of the recovery process and the individual's perspective on what influenced their transformation from victim to survivor, as well as exploring the person-environment transaction and its influence on their experience.

Although the literature provides some indication of possible areas to explore, it provides little information on the contextual influences of recovery in the work environment. Shalev et al. (1996) state that there is a dearth of literature on the effects of work rehabilitation programmes with PTSD. However, they note that the results of the work that has been conducted are impressive and further exploration of this as a major treatment approach is warranted. Solomon (1999) suggests that research is needed to investigate whether the effect of early contact is beneficial in aiding recovery from trauma. This is of specific relevance to work-related trauma, particularly in a worker's compensation framework in which early contact is seen as goal or service standard.

### Social Support

Social support is an important part of the ecology of the recovery environment. The breadth of research and its specific importance merits further exploration. Social support has been shown to be an important variable in recovery from trauma (e.g., Cook & Bickman, 1990; Flannery, 1990; Green et al., 1985; Lazarus & Folkman, 1984; Orford, 1992). Flannery defines social support as a multidimensional construct comprising of the comfort, assistance and information one receives through formal or informal contacts with individuals or groups. He further states that social support can be verbal or non-verbal and needs to be perceived as helpful.

Helpful social support is delineated into four types of social interaction, emotional support, information, social companionship and instrumental support. It appears that all of these types of assistance increase the amount of coping resources available to an



individual and as a result boosts their feelings of control in their situation. Harmful social support is also delineated into four types. These are value conflicts, emotional demandingness, emotional over involvement and interpersonal skill deficiency. Orford (1992) suggested that although the literature on social support varies, there appears to be a reasonable consensus that it contains at least three or four different components. The structure of social support is an important factor in the overall effectiveness that is perceived by the individual. Within this structure the factors that are viewed as important include; reliability of the source, acceptance versus rejection, accessibility of the support and the timing of the support given is also important. It is also suggested that the different sources of social support and types of social support may be beneficial at different times.

In a discussion of social support research methodology, Flannery (1990) stated that the majority of studies assess the quality of interactions, the quantity of interactions or the availability of social supports, whether or not the support was utilised. In relation to trauma research he reported that there has been little research on the role of social support in trauma recovery. Basoglu et al. (1994) explored the psychological effects of torture on Turkish political activists and concluded that having a strong support network has a protective quality in regards to the development of PTSD. Although it is clear that social support is helpful in recovery, how it is helpful is unknown (Flannery). Social support is often explored as a protective factor against PTSD but rarely in depth as a recovery factor (Basoglu et al.,).

The work of Cook and Bickman (1990) suggests that social support may act as a moderator to the impact of stress. Importantly, they note that the perception of social support and the actual amount of social support provided are often widely different. Further, they report an individual's subjective experience of social support is the most important aspect. Therefore, it would appear that an in depth review of an individual's experience of the social support they received and in particular, its perceived helpfulness in recovery from trauma is warranted.

Jacobson (1986) discusses the role of social support within a three-stage model of trauma. The stages are crisis, transition and deficit states. He defines the deficit state as a period in which the individual experiences chronic excessive demands. In viewing these as a sequence, Jacobson proposes that emotional support will be a suitable support in the

crisis phase. Whereas informational support will match with the transitional phase and material support will be appropriate for a deficit state. Thus, the emphasis is for social support to be appropriate in source, type, and timing following a traumatic event. This is of particular importance to individuals with work-related trauma. The worker's compensation system offers a number of supports to the worker such as counselling, medical contact and vocational rehabilitation. The usefulness of professional social supports and a picture of their importance and sequence in the recovery process as well as the impact of the system on an individual's current support warrant investigation.

Different types of social support are valued from different sources following a crisis (Lyons, 1991). Emotional support is considered valuable from friends and family whereas information from this group is intrusive. However, information is acceptable from professional sources. Advice and encouragement is of greatest use when it is offered by other victims. The literature is uncertain as to how social support influences coping. It may influence cognitive appraisal or it is suggested that social support provides feedback and assists problem solving (Lyons).

Individual's experience of social support within the worker's compensation system is currently unclear. Developing a clear understanding of its importance and role in recovery will facilitate improved interventions with this population. Further, exploring individual experiences in the system will further the understanding of natural supports and how these are facilitated or disrupted by their interactions with the system.

### Cognitive Appraisal

Internal mechanisms such as cognitive appraisal are not part of the ecology as such, however, they are strongly affected by it. How an individual appraises a traumatic event, how they appraise their own actions and their environment will have an impact on their recovery. As with social support the individual's perception of the situation is a key element.

Every individual holds a set of cognitive assumptions through which they make sense of the world they perceive around them. Janoff-Bulman (1985) suggests that the development of post-traumatic stress occurs largely because the trauma breaks the individual's assumptions about themselves and their world. He suggested that the process

of recovering from a trauma involves rebuilding these assumptions and integrating the traumatic experience into the individual's belief system in order to allow the individual to once again function effectively. Janoff-Bulman purports that there are three basic assumptions about the self and the world. These are; a) the belief in personal invulnerability, b) the perception of the world as meaningful, and c) the perception of oneself as positive.

#### Personal Invulnerability

The assumption of personal invulnerability refers to the general belief that "*it won't happen to me*" even though on a logical level the individual realises that car accidents, bank hold-ups and assaults occur on a regular and random basis. However, in order to be able to function effectively from day to day, individuals view themselves as unlikely to be a victim of trauma. This illusion is a mechanism to protect the individual from threat and the stress and anxiety associated with it (Janoff-Bulman, 1985). When a traumatic incident occurs this assumption is violated, that is, the individual can no longer work on the premise that "*it won't happen to me*" and thus feelings of vulnerability and helplessness may follow. This assumption in particular is closely linked with the person's sense of personal safety, once a violation of the assumption occurs it allows for the possibility that the assumption was wrong and another trauma may occur. This leaves the victim believing they may now experience a reoccurrence of trauma at any time and therefore they experience increased feeling of fear and apprehension.

#### The Perception of the World as Meaningful

In order to make sense of the world we view it as understandable and containing a sense of order. This enables us to make sense of events that happen and maintain the perception of a sense of personal control over what occurs. Further, having established this 'world theory' an individual can believe that they can prevent misfortune by controlling their own behaviour. Janoff-Bulman (1985) also stated that at some level individuals believe they are protected from misfortune by being good and deserving people. This assumption is challenged by a traumatic event, particularly if the individual believes they have been worthy and sufficiently cautious. In terms of the individual's view of the world, personal trauma is not deserved and therefore does not fit into their

cognitive schema. Thus, people search for meaning in their traumatic experience. In this way they attempt to cope with the trauma by making it fit into their world theory.

### The Perception of Oneself as Positive

The third assumption is that of a positive self-perception. Individuals tend to view themselves as deserving, decent people and through this assumption they are able to maintain a healthy measure of self-esteem. Thus, when an individual becomes a victim of trauma, it leads them to question not only their view of the world but also their view of themselves. Following a trauma, individuals tend to experience a loss in their sense of autonomy and control, which in turn can lead to questioning of themselves and subsequently a lowering of their self-esteem (Janoff-Bulman, 1985). Finding meaning in the event is a way of preserving the assumption of the world as ordered and just. A strategy for doing this is to attempt to assign a purpose to the event having occurred. By doing this the individual can reestablish their belief in the ordered and just world.

According to Janoff-Bulman (1985), post-traumatic symptoms may be produced by these schemas about the world being challenged. Without these assumptions intact, serving as guides to make sense of the world, the individual is unable to function effectively. The cognitive assumption of a sense of order or justice in the world impacts as an external factor as well as through the individual's personal appraisal system.

The basis of Janoff-Bulman's (1985) theory of trauma recovery is comparable to earlier work by Horowitz (1976) and more recent researchers (e.g., Roth & Newman, 1991; Schneider, So-Chiew Ee & Aaronson, 1994). It is commonly suggested by these authors that successful recovery from trauma involves integrating the experience in order to reduce the challenge to their assumptive world.

An individual who views themselves as a victim may engage in different behaviours in order to reestablish a sense of control and minimise feelings of vulnerability. Janoff-Bulman (1985) uses the example of crime victims engaging in preventative behaviours such as moving residence, changing locks and installing security systems. Even though this may only be a perception of an increase in control, this allows the individual to rebuild their assumptive world by reestablishing a sense of control and subsequently a more positive self-image.

A way of attempting to reconcile the lack of control experienced is to engage in self-blame regarding the trauma. Janoff-Bulman (1985) reported that victims attribute more blame to themselves than is warranted by the actual circumstances surrounding the trauma. However, self-blame may have an adaptive function. He suggested that there are two forms of self-blame. The first is behavioural self-blame, this is an adaptive response in which an individual blames their own behaviour. The second is characterological self-blame, this is described as when a person attributes maladaptive blame to their character or personality. The key difference between these two types of blame is the degree of modifiability that can be asserted over the factor.

A person who engages in behavioural self-blame maintains a higher level of self-esteem and believes they can modify their own behaviour thus avoiding future trauma and retaining a sense of order and control. An individual who engages in characterological self-blame will see themselves at fault and view their behaviour as relatively unchangeable. Janoff-Bulman (1985) noted that behavioural self-blame is only adaptive if it occurs without characterological self-blame. However, they are likely to co-exist.

Cognitive appraisal of the trauma is an integral step in beginning and continuing the recovery process. Joseph, Yule and Williams (1993) state that the emotional processing of a traumatic event interacts with factors within the individual and with his or her social environment. Thus, the recovery environment may have a large impact on the individual's appraisal of the trauma and his or her own ability and resources to recover from it.

Lazarus and Folkman's (1984) work on cognitive appraisal appears to provide a basis for psychological growth or positive adjustment theories. They view appraisals of stress as being viewed as harm/loss, threat or challenge. A challenge appraisal is seen as an opportunity for growth through the mobilisation of coping strategies. Whereas a threatening appraisal would induce feelings of fear, anxiety or anger, a challenge appraisal may illicit hopefulness and confidence. They believe these concepts are not on a continuum but rather separate concepts that may occur simultaneously. As the situation or event changes the appraisal of threat may change to challenge or vice versa.

Most individuals who experience a traumatic event attempt to come to terms with the experience through reviewing it (Lyons, 1991). It appears that mental re-exposure to the event is an important way to integrate the trauma. Researchers have shown that children attempt to deal with trauma through re-enactive play (Terr, 1983; 1985). According to Lyons those individuals who display the most voluntary control over their re-experiencing of the trauma are the most likely to show long-term positive adjustment.

Feinstein and Dolan (1991) emphasise that not every person that is exposed to trauma develops PTSD. They note the influence that environmental factors have on a person's subjective response to a traumatic situation. Feinstein and Dolan view the stressor as a '*trigger*' not a causal factor. Their findings support the idea that the nature of the traumatic event is not of primary importance in the prediction of PTSD. They suggest that difficulty with cognitive assimilation of the event has the greatest influence in predicting PTSD. This perspective has clear implications for theories of cognitive appraisal in recovery. If the way in which an individual appraises the event itself is predictive of PTSD diagnosis, it is reasonable to assume that the way in which an individual appraises themselves and their environment post-trauma will have a large impact on their recovery. Similarly, Wilson, Smith and Johnson (1985) stated that trauma is cognitively processed based upon interactions and relationships between dispositional variables and situational variables. An individual who experiences a work-related trauma will encounter a number of unique and powerful environmental influences, such as the worker's compensation system. The worker's compensation system has far reaching effects, from where the individual can access psychological support, to how other people perceive them.

Thus, the worker's compensation system in many ways imposes a framework on an individual's recovery without the individual having any control over the process once in the system. When looking at recovery in a PTSD population, which typically involves feelings of lack of control, distrust and hypervigilance, it is important to develop a clear understanding of the impact and influence that the worker's compensation system has on the individual's cognitive appraisal. In particular, investigating the dynamic interaction and influences of the system on the individual and those around them. By doing this it may be possible to influence the recovery environment in order to facilitate the individual

to interpret the event in a way that allows them to integrate it into their experience and move forward.

The literature suggests that an individual's cognitive appraisal of the trauma influences their recovery and their environment. Conversely, the environment can positively or negatively affect cognitive appraisal. The literature does not illuminate the effect the experience of being in the worker's compensation system has on either cognitive appraisal or on the recovery environment which may be of significant influence.

### Coping Style

As with cognitive appraisal, the way in which an individual copes with a traumatic experience will be profoundly affected by the environmental and contextual factors in their recovery environment. Coping may be defined as the way in which an individual manages the environmental and contextual influences surrounding a traumatic experience and the action chosen as a result of their appraisal of the event (Baldinger & Nelson, 1995). Coping is complex and multifaceted, individuals utilise a variety of both problem focused and emotion focused strategies to attempt to deal with stress (Holyroyd & Lazarus, 1982). Coping and cognitive appraisal are intertwined, individuals who experience trauma cope either by cognitive strategies or by direct action (Janoff-Bulman, 1985).

Coping does not necessarily equal mastery. Coping may mean tolerance or minimising stressors that cannot be mastered (Lazarus & Folkman, 1984). As the person and environment interaction changes the individual needs to be able to shift their coping approach. For example, using problem solving approaches to deal with the practicality of sudden death and then using emotion focused coping to begin to deal with grief. Like Janoff-Bulman (1985), Lazarus and Folkman view coping and appraisal as integrally linked, the individual's reappraisal of the trauma leads to continuing changes in coping.

Emotion focused coping strategies aim to lessen emotional distress. These may include avoidance, minimisation, distancing, positive comparisons or selective attention. Some forms of emotion focused coping can change the way in which the event is perceived without changing the objective situation, just as cognitive appraisal. Other

emotion focused coping does not change the meaning of the event directly but rather screens out portions, for example the use of selective attention. Problem focused coping includes both strategies directed at the individual's environment and strategies that are directed inwardly. This usually involves finding strategies to manage or solve the problem. Emotion focused coping and problem focused coping can either aid or impede each other and can co-occur. Focusing too much on emotion based strategies can impede the use of problem focused coping when it is needed (Lazarus & Folkman, 1984).

The way in which an individual chooses to cope will largely be determined by the resources they have available to them within the context of their own, unique environment (Lazarus & Folkman, 1984). Coping resources include internal and external factors, such as the individual's health and energy, positive beliefs, problem solving skills, social skills, material resources such as finance and social support. Factors that inhibit individuals from using their available coping resources include personal factors such as internalised cultural beliefs and values or environmental factors such as financial constraints (Orford, 1992).

Shontz (1984) proposed that when an individual undergoes a crisis without warning, such as a serious physical injury, they proceed through coping stages. The first stage is shock, this may present as feelings of detachment or in other cases acute clarity of thought and action. The second stage is the encounter stage. It is suggested that at this point the individual may experience disorganisation, helplessness and panic. The third stage is retreat, which is a period of withdrawal and numbing. From this point the individual engages in shifting back and forth between confrontation of fear and avoidance. This is a type of reality testing that allows the individual to shift back and forth in an effort to overcome the trauma. It is of note that the withdrawal is not seen as maladaptive but is an important strategy to prevent breakdown by allowing the individual to feel secure. As recovery occurs, the cycles of moving back and forth lessen until they are no longer necessary. This process is considered to be a prerequisite to personal growth through an increased sense of satisfaction, personal worth and a reduction of anxiety.

In discussing the relationship between PTSD and post-trauma factors, Harrison and Kinner (1998) propose an integrative relationship between symptom and recovery



factors. They note that avoidance is a key concept in PTSD diagnosis and the use of avoidant coping strategies has been linked to greater distress. It is suggested that avoidant strategies prevent the individual from cognitively processing the trauma and therefore the individual stays in a state of psychological distress and elevated arousal. Avoidant strategies are often used to attempt to increase the individual's sense of personal control over their situation. The concept of control is clearly linked to coping. Control strategies are often utilised to attempt to cope with trauma. When a situation appears to be out of control an attempt is made to regain a sense of control. An individual faced with a traumatic event may attempt to alter the environment, change the meaning of the situation or minimise their emotional and behavioural reaction to it (Solomon, Mikulincer & Avitzur, 1988). Individuals who experienced a lack of control in their day to day living prior to trauma have an increased risk of developing psychological difficulties (Baldinger & Nelson, 1995).

The individual's recovery environment may influence their ability to make decisions and seemingly take control of the situation. The constraints and assistance of the worker's compensation system may affect the individual's appraisal of the situation and therefore the ways and means in which the individual chooses to cope with the trauma. Viewing recovery from an ecological perspective allows a closer exploration of the interaction of the environment and external factors and the individual's internal coping resources.

### Physical and Psychological versus Psychological Injury

Sustaining a physical injury during a work-related trauma may mean receiving different treatment and services during recovery. It is important to explore the effect that the individual's environment will have on their recovery, both positive and negative. Further, it is important to explore any similarities or differences in their experiences. In particular, what impact the worker's compensation system as a contextual influence has on these two groups.

The literature suggests that individuals who sustain physical injuries from a trauma are at particular risk for developing PTSD. Specifically, the greater the physical injuries sustained the more likely it is the individual will develop PTSD (Blanchard et al.,

1996; Bromet, 1996; Green, McFarlane, Hunter, & Griggs, 1993; Koren, 1999). This is known as the dose-response effect. The research in this area has focused on the prediction of PTSD, however, there appears to be little research on the similarities or differences in the recovery of these two groups. Although the likelihood of developing PTSD is greater, this does not automatically mean that those who sustain a physical injury will experience the same recovery process as those who did not sustain a physical injury.

The presence of a physical injury is not a recovery factor per se` however, it is strongly linked with the aspects derived from the literature to be explored. In particular, the attitude that bodily injury is more serious than psychological injury (Schneider, et al. 1994). Thus, individuals with a psychological injury may face different difficulties and barriers to recovery than those in the worker's compensation system that sustain physical injuries. This study explores the effect that environmental and contextual factors have on the recovery experiences of these two groups.

There is mixed evidence as to the relationship between physical injury and the development of PTSD. Blanchard et al. (1996) assessed 158 individuals four months after they experienced a motor vehicle accident [MVA]. Included in the study were individuals who sought medical attention due to the accident. They found that 39% of their sample met the diagnostic criteria for PTSD according to the DSM-III-R.

The severity of the physical injuries sustained is a significant predictor of subsequent development of PTSD (Koren, 1999). Koren notes that this is one of the most reliable predictors of PTSD in MVA victims. In a review of victims of crime Kilpatrick et al. (1989) state that this group of individuals are at a high risk for developing PTSD. Further, individuals who are physically assaulted show greater distress than those who are not physically assaulted (Kilpatrick et al.).

Both Feinstein and Dolan (1991) and Green et al. (1993) report that there is no relationship between physical injury and the onset of PTSD but perceived threat is a significant predictor. Similarly, Green et al. found that PTSD development was not related to the severity of physical injury but was related to perceived psychological threat to life. It would therefore appear relevant to explore an individual's perception of their experience. All of the discussed papers explore physical injuries as a predictive factor of

PTSD. Physical versus psychological trauma as part of the recovery experience is not discussed.

Schneider et al. (1994) stated that psychological recovery may be linked to extent of physical injury the victim sustains during a trauma. They note that this is particularly the case when ongoing medical treatment is required. They also found that observers believed that the psychological aftermath of rape would take longer to heal than the physical aspects even when serious physical injuries were described. However, they report that both genders rated physical harm as more serious than psychological harm. It has been suggested that physical injury is destructive to the victim's sense of personal safety and integrity and also to their sense of self-competence (Baldinger & Nelson, 1995). Therefore, physical injury may have a deep and lasting effect on the victim's belief system. When applied to Janoff-Bulman's (1985) model, this shattering of self breaks all three basic assumptions.

Green et al. (1993) investigated PTSD following MVA's and found that approximately one third of their sample developed PTSD, of that group not one person was diagnosed with PTSD or offered psychological intervention of any kind. They also note that the compensation system does not ensure that these individuals receive treatment even if they are psychologically assessed for litigation purposes. The work of Green et al. reveals a possible blind spot to psychological trauma that may be largely affected by the influence of the environment such as the worker's compensation system. The constraints or influence of the system may affect not only the type of intervention an individual receives, but also whether they receive intervention at all.

### Psychological Growth

When viewing a phenomenon such as trauma recovery from an ecological perspective it is important to view the possibility of positive influences of the environment that may result in psychological growth. The idea of psychological growth from trauma has been recognised clinically for some time. However, Calhoun and Tedeschi (1998) report that recent investigations of the concept have confirmed its occurrence in a significant proportion of individuals suffering a wide range of distressing events. Research on positive adjustment following traumatic experiences is often

overlooked (Harvey, 1996; Lyons, 1991; Smith, North, McCool, & Shea, 1990). More often pathology is explored in an attempt to explain post-trauma behaviour. It has only been recently that this more positive focus has occurred (O'Leary, 1998).

Tedeschi, Park and Calhoun (1998) describe posttraumatic growth (PTG) as both a process and an outcome following trauma. They view PTG as having developed from a cognitive process that is initiated to deal with the cognitive and emotional impact of traumatic events. They note that in the emerging literature on this topic there have been a variety of terms used such as thriving (O'Leary & Ickovics, 1995), positive illusions (Taylor & Brown, 1988) and stress-related growth (Park, Cohen & Much, 1996). They propose that the best term is posttraumatic growth because it makes clear that the person has progressed beyond their previous level of adaptation and it makes clear that this positive growth has occurred following a negative event.

Calhoun and Tedeschi (1998) suggest three main domains in which positive change occurs. These are changes in self-perception, a change in relationship with others and a change in philosophy or outlook of life, usually this includes a stronger appreciation for life and new goals and direction. The authors suggest that following a trauma an individual's self perception may not be shattered and vulnerable as suggested by Janoff-Bulman (1985), some individuals develop a self that may be described as capable and reliant, particularly in the face of challenge.

A change in a significant relationship appears to encompass a sense of greater emotional closeness to one or more person's, a perception of greater freedom to express emotions and to feel sympathy or understanding for others. Several studies in this area have indicated a relationship between PTG as reported by trauma survivors and measures of psychological adjustment. However, other studies such as Joseph et al. (1993) have reported no significant relationship between self-reported positive changes and adjustment. As yet there has not been a satisfactory explanation for this inconsistency. Although the data is inconsistent there is no suggestion that perceived positive growth is in anyway linked to negative psychological adjustment. Thus, discussing subjective perceptions of growth would appear important particularly when exploring recovery from the perspective of those individuals who no longer meet the criteria for PTSD.

Psychological growth and distress may co-exist. Further, experiencing ongoing distress may serve as a catalyst for further growth (Calhoun & Tedeschi, 1998). It is proposed that psychological growth is an outcome of the same set of events that produce psychological distress. An individual typically must experience an event that is capable of shaking, if not shattering the individual's assumptive world and may lead to the rebuilding or re-evaluation of beliefs. It is this change to assumptions that can produce both growth and distress, as the structure and meaning previously assumed fundamental is no longer certain. Psychological growth and good coping skills are not the same concept although they may co-occur. Calhoun and Tedeschi suggest that for an individual to be able to experience psychological growth some positive coping needs to have occurred initially post trauma.

Currently, there is little evidence on the factors that influence positive adjustment. At present factors such as self-confidence, easygoing disposition, physical resistance, family support, hardy disposition, active approach to challenge, and social resources are being explored (Calhoun & Tedeschi, 1998). Coping style also appears to be important in readjustment. In particular, the use of problem solving approaches, This style of coping is strongly associated to positive adjustment following a variety of life stressors. Specifically, individuals who engaged in externalisation, wishful thinking and extreme avoidance presented with significantly more PTSD symptoms than those who utilised more active coping styles (Wolfe, Keane, Kaloupek, Mora & Wine, 1993). An individual's ability to find meaning and selectively evaluate the crisis appear to foster successful outcomes (O'Leary, 1998). The search for meaning in the traumatic event is a major facet of the overall cognitive appraisal of the event. Lyons (1991) states that positive adjustment is linked to finding meaning. It appears that the nature of this relationship is unclear, in particular how this process helps.

Calhoun and Tedeschi (1998) note a number of individual and societal factors that can influence the possibility of PTG. They suggest that clinician's work with an individual's belief system including religious and spiritual changes can assist by questioning and supporting perceptions of growth when they occur. The style and content of an individual's cognitive process is clearly related to subsequent adaptation following trauma. In particular, negative self-focused thinking is maladaptive whereas positive

cognitive changes such as perceptions of increased independence are more likely to produce psychological growth.

All of the individual factors that interact to influence change operate within a larger system. Calhoun and Tedeschi (1998) acknowledge the importance of the social context in which recovery occurs. They report that there is a direct link between the response of an individual's social network and the individual's reporting of both positive and negative expressions in relation to trauma and subsequent psychological growth. However, they state that this area is largely uninvestigated.

Saavitne, Tennen, and Affleck (1998) looked specifically at PTG in the context of trauma theory. They note that responses to trauma are always embedded in the individual's socio-cultural context. In their review of the research in this area they report that traditionally responses to trauma have been explained in terms of individual characteristics. However, it is important to account for the unique interaction of the individual, the environment, and his or her circumstances. They conceptualise adaptation to trauma as an interaction between the trauma context, the individual's history and the social and cultural contexts in the recovery environment. The constructivist nature of this model assumes that it is the individual's interpretation of events and their meaning that will determine outcome. Therefore, the present study addresses this issue by viewing recovery from an ecological framework and exploring the individual's perspective on their recovery experiences.

Although the models presented can theoretically be applied to the work-related trauma population as yet the viability of this has not been explored with this population. It would appear important to do so in light of the unique factors with which this population presents.

### A Theoretical Framework for Understanding Recovery

All of the factors reviewed are part of the individual's own unique recovery environment. The ecological factors reviewed may be conceptualised within Harvey's (1996) model of trauma recovery. Harvey's model is based upon the work of Bronfenbrenner (1977) and is particularly useful in understanding recovery. Harvey views recovery within an ecological framework. She conceptualises trauma recovery as

an interactive process between person, event, and environmental factors. The relationship between these factors, the individual and their community may either foster or impede the recovery process. Harvey believed that interventions should aim to enhance the individual's relationship with their community. Harvey stated that the focus of clinician's understanding has been on the pre-traumatic characteristics of the victim and the duration of the victim's exposure to the traumatic stimulus. However, she suggests that the way in which the individual interprets the event and the larger environment surrounding the individual are of equal importance. She notes that the current psychological literature does not emphasise the importance of environmental factors in the process of trauma recovery.

Harvey (1996) defines an ecological framework, suggesting that human behaviour is best understood within the context of the communities in which they occur. Thus, an individual's reaction to a traumatic event will be influenced by the values, beliefs behaviours and understanding that the individual's community has instilled in its members. Thus, utilising this framework entails focusing on the experience of recovery (including the worker's compensation system) and determining its impact on the recovery experience. The worker's compensation system may have a significant influence on recovery, both by placing constraints on the recovery process (for example, legislation regarding entitlement to services) and as a significant part of the environmental context.

The actual concept of 'recovery' in the literature is rarely discussed in any depth and is seldom defined. Further, the authors in this area do not outline a set of necessary components for trauma recovery and therefore it is difficult to compare studies.

Harvey (1996) addresses these concerns by presenting an ecological definition of recovery and a model of the recovery process. Harvey's ecological model of trauma proposes three assumptions. Firstly, individuals are neither equally vulnerable to nor similarly affected by potentially traumatic events. She suggests that interactions between the persons involved and their relationships to one another, the event characteristics, and the larger environment determine vulnerability and response to trauma.

The second assumption is that after a trauma individuals may or may not access clinical care. Harvey (1996) states that the majority of victims will not and that the recovery process of those who do not access clinical care is an important area for

research. The third assumption of the model is that clinical care after trauma is no guarantee of recovery.

Recovery is often linked to overall general mental health. Therefore interventions that use global outcomes and do not distinguish for trauma do not add to our understanding of the specific recovery process nor do they aid in the design of truly effective interventions. At the other extreme, some focus only on the specific symptoms of arousal and intrusion and equate recovery purely with symptom abatement. This is a culture of absences, that is, an absence of nightmares, intrusive thoughts or sweating equals recovery. This approach fails to account for aspects of trauma such as feelings of self-blame, mistrust or guilt of surviving that can persist chronically after symptom abatement (Harvey, 1996).

The strength of this model lies in its ability to encompass all individuals who suffer from trauma. It covers those who seek treatment and recover, those who seek treatment and fail to improve and those who seek no formal psychological intervention and recover and those who do not recover. Further, it incorporates resiliency and the possible positive benefits of recovery from trauma. Harvey (1996) expressed that recovery within this framework occurs whenever a poor outcome is changed to a positive outcome in any domain affected by traumatic exposure. Resilience occurs when either a domain remains unaffected by the trauma or the survivor mobilises strengths or coping resources in other domains to cope with a deficit in another.

### Research Questions

Utilising an ecological framework allows for an in depth exploration of the personal impact of contextual factors such as the worker's compensation system on the recovery experience. The present study aims to explore individual experiences of recovery from work-related trauma within an ecological framework. Specifically,

1. What are the experiences of recovery for individuals with a work-related trauma within the context of the worker's compensation system?



2. What factors facilitate or inhibit the recovery experiences of individuals who sustain a physical and psychological trauma versus individuals who sustain a psychological trauma?

## Chapter Three

### Method

#### Methodological Issues

Saavitne et al. (1988) note a number of criticisms in the research literature on posttraumatic growth (PTG). They report that the errors of research that are appearing in the PTG literature are the same problems that have occurred in the coping and vulnerability literature. It appears that the majority of the work on PTSD suffers from the same problems. One of the problems they identified is the focus on relations between variables across individuals instead of studying psychological processes. They note that a more idiographic approach allows the examination of variables and relationships within an individual instead of between person associations. By studying concepts in this context the investigator can explore how processes occur and change over time. A combination of these two approaches allows for the exploration of processes over time and then an exploration of whether these processes generalise between individuals.

Similarly to Calhoun and Tedeschi (1998), Saavitne et al. (1998) view PTG as a process as opposed to a static variable. They describe the 'snapshot' view of the process as unsatisfactory, this is also applicable to the current trauma recovery literature. Saavitne et al. suggest that the research literature on stress, vulnerability, coping and thriving needs to broaden its conceptual focus to include intra-individual processes that unfold over time. It is important to note that information gleaned from an intra-individual approach can differ greatly from information derived from an inter-individual approach. Therefore, when asking an individual questions it is important to attempt to answer them using an appropriate approach. They emphasise that a focus on intra-individual factors can transform variables into processes and that these processes cannot be obtained through inter-individual approaches alone. It is vital to approach investigation from multiple angles. The richness of the data can only be enhanced when these approaches are integrated. As the nomothetic approach has remained dominant in the literature it is important to increase research derived from an idiographic framework (Saavitne et al.,).

Saavitne et al. (1998) emphasise the importance of generating clear descriptive information on an intra-individual level about the process of recovery. In particular, the subjective viewpoint, as research indicates that it is the subjective construction of reality

that is the most influential in determining outcomes (Harrison & Kinner, 1998). The methodology utilised in this study addresses some of the problems highlighted by Saavitne et al. By utilising an idiographic approach this study allows the recovery experiences of individuals to be viewed as a process from a subjective standpoint. Utilising a multiple case methodology allows the subjective expertise of individuals who have experienced the recovery process to be drawn upon. The participant's knowledge then builds a picture of the recovery process as it unfolds. This also creates a base upon which further inquiry can build.

### Multiple Case Design

The aim of this research was to work within an ecological systems perspective utilising the experiences of participants in order to develop rich and detailed information regarding their recovery experiences. A multiple case design was deemed the most appropriate method to achieve these aims. Stake (1994) stated that case study design is not a methodological choice but rather a choice of object to be studied. That is, the multiple case design utilises a number of cases to explore the uniqueness of each case while facilitating an in depth exploration of the phenomena in question, both at an individual level as well as a collective level, highlighting connections, similarities and differences between individuals (Burgess-Limerick & Burgess-Limerick, 1998). Campbell and Ahrens (1998) note that the advantage of the use of multiple case design is that it allows for multiple perspectives on real world concepts. Thus, this method was ideally suited to an intensive investigation of recovery from work-related trauma.

Within the multiple case design the study utilises the qualitative approach of focused conceptual development (Pigeon & Henwood, 1997). Focused conceptual development describes an iterative relationship between the data and the literature. The aim of this approach is also to view the phenomena holistically and comprehensively (Denzin & Lincoln, 1994). This is an interpretive approach involving in depth interviews and analysis of the subsequent textual material to derive meaning and insight into the area of study (Smith, 1995).

In addition to interviews with participants, data was gathered from a variety of sources including key informants and archival data from case files. This triangulation of

data sources ensures a variety of perspectives and a comprehensive database. Further, the respective strengths and biases of the data sources complement each other to facilitate a corroboration of emerging theoretical constructs and well as highlighting inconsistencies or discrepancies (Miles & Huberman, 1994).

### Participants

There were seven participants in total. This included five primary case studies comprising four males and one female ranging in age from 37 to 51 years ( $M = 44.6$ ,  $SD = 6.58$ ), and two secondary key informants both female with four and eleven years of experience in working with stress claims in the worker's compensation system in Western Australia (WA). Three primary participants had sustained physical injuries from the trauma as well as posttraumatic stress disorder and two primary participants had developed posttraumatic stress disorder but had not sustained a physical injury during the trauma. All of the primary case study participants had lodged a worker's compensation claim citing the claim basis as a 'stress related injury' in WA.

All case study participants in the sample had participated in vocational rehabilitation. All cases were closed at the time of the study and had not been seen by the researcher in any capacity prior to the study. Freedman, Brandes, Peri and Shalev (1999) state that the majority of individuals with PTSD recover within a year. If the disorder persists beyond one year it is likely to become a chronic condition. The participants were screened to ensure the date of incident occurrence was a minimum of one year prior to the study and that at the time of the study the participant no longer met the criteria for PTSD. The aim of this was to attempt to derive a sample of individuals who had experienced PTSD and recovery but not those who would still significantly suffer from symptoms or had developed a chronic disorder.

The number of participants used in this study requires comment. Initially the aim was to obtain a larger sample however, due to the availability of participants and the strictness of the selection criteria five primary case participants was the maximum number possible. Nevertheless, Burgess-Limerick and Burgess-Limerick (1998) state that in multiple case design a small, purposive sample is suitable. The advantage of utilising a sample of this size is it creates a capacity for the researcher to investigate each individual

as a separate case while also allowing a comparison between cases to illuminate similarities and differences (Burgess-Limerick & Burgess-Limerick,).

### Materials

A semi-structured interview was devised on the basis of the literature review and the information provided by the key informants. The creation of the semi-structured interview was built upon information derived from collaborative interviews with the key informants.

All interviews were taped and professionally transcribed in order to maximise the validity of analysis. The interviews took the form of conversational interviews followed by questions derived from the literature review, this was done to avoid confining the secondary informants to pre-constructed categories. By not engaging in a structured process initially, issues other than those perceived as relevant in the literature were explored and a richer data pool developed. This is in line with the notion of funnelling (Smith, 1995). The secondary informant interviews were then analysed into substantive categories and secondary analysis was undertaken to derive formal categories. These were then added to the information gathered from the literature review to form the basis of the interview schedule (See Appendix A). Questions included asking participants what was helpful and unhelpful in aiding their recovery, positive and negative outcomes of the experience and specific questions on their perception of the social support they received from different sources.

### Procedure

The rehabilitation provider was asked to generate a list of closed client files that involved a lodged claim for a stress-related injury in the Western Australian worker's compensation system. The rehabilitation provider was then asked to narrow the list to cases that involved claims at least or greater than one year old. Only those files that had a written, confirmed diagnosis of PTSD following the incident were reviewed. This information was typically confirmed by medico-legal reports, psychiatric reports or clinical psychologist progress reports.

Those individuals who then met the above criteria were sent a letter requesting their participation and a general letter of information by the investigator. The rehabilitation provider requesting their participation followed up this correspondence with a telephone call a week later. The names, telephone numbers, and files of those agreeing to participate were then passed onto the investigator.

The files of those agreeing to participate were then reviewed again. Information on file and the initial screening checklist was used to confirm a diagnosis of PTSD. This checklist was developed based on the DSM-IV (APA, 1994) diagnostic criteria for PTSD. The checklist was then administered over the telephone prior to the interview to determine whether the participant no longer met the clinical criteria for PTSD. Those who had not received a clear diagnosis of PTSD or did not have enough conclusive information on file to be able confirm this diagnosis were excluded from the study. The investigator then telephoned the participants meeting the criteria. During this telephone call general information about confidentiality and the purpose of the study was given and any general questions answered. The screening questionnaire was then administered over the telephone. Any subject who met the criteria for PTSD at the time of the telephone call was excluded from the study and advised to see their general practitioner. Those subjects with a cumulative claim and any ongoing litigation were also excluded. At this time an appointment was organised for the interview with the suitable participants at their place of residence.

Prior to conducting the interview, the informed consent, general information, and any questions were discussed with the participant (see Appendix B). Each interview was tape-recorded using a journalist quality microphone for clarity of sound and all interviews were professionally transcribed.

## Chapter Four

### Analysis and Findings

#### Data Analysis

Qualitative analysis involves describing in detail the ways in which people in specific settings come to understand, account for, take action and manage particular phenomena. The process involves identifying and developing categories from the participant's descriptive material and developing these to allow the researcher to contrast, compare and analyse possible patterns or areas of interest (Miles & Huberman, 1994).

Consistent with the case study approach, data analysis was conducted utilising the idiographic approach suggested by Smith (1995). All interviews were transcribed verbatim in order to maximise the validity of analysis and each interview transcript was reviewed and analysed in detail separately prior to moving on to the next transcript. The transcript was read through on multiple occasions. Throughout these readings notes were made of any perceived interesting or significant points made by the respondent. In order to categorise the data, the emergent themes from the literature review were utilised. A coding scheme was developed using a combination of these themes and any significant themes that emerged from the initial readings of the transcripts.

Secondary analysis was conducted on the resulting codes utilising the approach outlined by Miles and Huberman (1994) and Smith (1995). Emergent themes were extracted and summarised, then examined for verification and regrouped if necessary. The numbered utterances and previous coding level was noted under the theme. The emergent categories and codes were then compared. Member checking was employed in order to verify data where possible. Although limited, this involved discussing findings with two participants, one key informant and one primary participant. They were asked to verify the investigator's understanding and interpretation of their transcripts.

The information from the interviews was then compared to the information derived from the participants vocational rehabilitation file. The files were analysed using a process of qualitative document analysis. Each file was reviewed with the same qualitative document analysis protocol (Miles & Huberman, 1994).

A protocol was developed to ensure standardisation of analysis. The aim of the document analysis was to look for barriers to the participant's recovery or factors that appeared to facilitate their recovery. A document contact sheet was developed based upon the work of Miles and Huberman (1994) and adapted to the specific needs of the study (see Appendix C). The information was then collated on a file summary form for further analysis (see Appendix D). The file summary form depicts visually a tally of the information provided from the file. This form depicts the document type and the issues derived from it, divided into positive and negative factors.

Every vocational rehabilitation file must conform to strict standards outlined by WorkCover Western Australia (the worker's compensation governing body). As files may be subpoenaed in court cases each contact relating to the worker's progress with any party involved is carefully documented. This includes telephone calls to the client and from the client, liaison with doctors, specialists, employers, insurers and any other party who has contact with the case. The vocational rehabilitation provider also had strict standards and written protocols governing file management. Senior staff review files once a year for quality assurance. These standards include provision of a monthly progress report, protocols on how to write file notes and procedures for when, how often, and how key parties should be contacted. Thus, the files provide a rich source of information presented in a standardised manner.

An advantage of reviewing these files is not only the standardised manner in which the information presents. These files also provide a variety of sources upon which to draw. Progress reports are not only from the rehabilitation provider. Because the provider works as a case manager or coordinator the files also have copies of reports written by doctors, specialists, insurer's, clinical psychologists, medico-legal reviews and second and third opinion specialists. Thus, the files provide a rich source of expertise upon which to draw.

### Findings

Although the recovery process is unique for each individual, consistent with the multiple case methodology the findings of this study suggest that there are some elements of recovery that are common to all of the participants. In the following section, the data from the key informants is outlined to provide a professional perspective on the recovery



process. Following this, the information provided by each participant is presented. In order to remain true to the idiographic approach adopted by this study the findings are presented as individual cases with the voices of each participant used frequently to illustrate the emergent themes. In chapter five and six an integration and synthesis of the findings across all cases and their implications are discussed.

### Key Informant: Jane

#### Background

Jane is the manager of psychological services at a vocational rehabilitation firm in Western Australia. She has a master's degree in organisational psychology and has been working with worker's compensation stress claims for seven years.

#### The Recovery Process

Jane reported that an individual who experiences a work-related trauma may approach their recovery in one of two ways. Either the individual takes an active, recovery focused approach or a passive, sickness focused approach. An active approach includes the utilisation of available resources, making a conscious decision to recover, taking responsibility to recover and seeking out information and resources to assist in the process. According to Jane, a passive approach involves the individual being focused on the symptoms, using maladaptive coping strategies such as avoidance, isolation and dependence which result in a transferring of responsibility for recovery from the individual to the medical profession or people other than the individual themselves.

Jane stated that the individual also moves through what she described as a cognitive recovery process. At first, everything in the environment is viewed as threatening. If the individual begins to successfully recover, their view or appraisal of the event changes. The individual's perspective changes from viewing the world as a threatening place to appraising the trauma as an unusual event in an otherwise relatively safe world. The individual's recovery environment has a significant impact on whether they take an active or passive approach to their recovery. Jane stated that the involvement of the employer is crucial immediately following the incident in order to reassure the individual and give recognition to his/her injury:

*...it helps, through the recognition that what happened to them is a real thing... rather than ...you're making this up' ...attitude.*

A lack of recognition from the employer can have a significant impact on how the individual views their situation. The lack of recognition can lead to cycle of symptom perpetuation by reinforcing the individual's need to legitimise their injury;

*People who don't have employer support get into a role where they need to keep showing how disabled they are...which impacts on other areas of their life as well.*

This may lead into a cyclical pattern of the individual attempting to justify their illness by showing it, as a result they cease trying to get better and become more ill. Jane described this cognitive set as follows:

*"Well, if I can't return to work, I can't leave the house....do any hobbies...go to the gym or go walking"... It turns into a cycle where they actually justify their non-return to work by giving up daily activities.*

Jane described appropriate employer support as practical, flexible and tangible. The employer needs to show support in a practical way in order for the worker to see that they are supported and that the employer recognises the legitimacy of their injury.

Jane expressed that the initial support the individual receives from the medical profession can have a similar effect. She stated that the role of the individual's doctor is also to recognise and validate the person's psychological difficulties.

Jane noted that medication needs to be appropriate and balanced in order to be of assistance. The initial action taken by the doctor can shape how the individual conceptualises the recovery process. Thus, it is important that the doctor take into account the individual's unique context, not just the symptoms in order to facilitate the recovery process. Jane reported that in her experience a number of doctors perceive incapacity to work as an 'all or nothing' variable. This coupled with negative employer attitudes has an impact on the length of time it takes for an individual to recover. Jane suggests it may actually perpetuate the symptoms;

*Doctors may not recognise that ...returning to work can actually be part of the treatment....somebody does not have to be fully recovered before*

*they're actually looking at a return to work, that return to work can actually play a role in assisting someone to full recovery.*

Social support from the family may also either facilitate an active or passive approach to recovery. Jane stated that social support from family members is extremely important. However, this needs to be appropriate and not cause an increase in the individual's psychological symptoms. Jane noted that the individual's family members can assist by attempting to normalise the experience and get them back to facing the problems of everyday life. She describes this approach as follows;

*'I can see you're having a hard time, what can we do to assist' ...and assisting with normalcy of like... 'I'll come for a walk with you'.*

Unhelpful family support is that which reinforces the individual's symptoms by encouraging dependence and assisting in a role of learned helplessness;

*They can help the symptoms continue by doing things like ...doing someone's shopping for them, rather than maybe taking them shopping.*

The context of the worker's compensation system places added pressure on the individual to demonstrate the legitimacy of their injury. The adversarial nature of the system requires the individual to constantly show how disabled they are. Thus, the nature of the system creates a situation in which the individual is compelled to 'prove' they have suffered as a consequence of the trauma. The context surrounding the individual causes a constant focus on the level of severity of symptoms. Thus, the individual's focus is repeatedly on their symptoms instead of their recovery or any improvement;

*Usually they have to go to a reviewing psychiatrist or psychologist and show again how disabled they are... so that can put them back into a pattern of showing how disabled they are, rather than the focus on recovery.*

According to Jane a physical injury may be seen as more legitimate than a psychological injury because of the tangible evidence that may exist. Any type of delay in treatment can facilitate an entrenching of maladaptive coping that delays recovery. Jane reported that some individuals choose to avoid feared situations and therefore become isolated. This prevents them from continuing to recover as they become stuck and are unable to regain a sense of control over their environment;

*They don't make choices, they don't get back to ...normal daily living activities, they may be housebound....selective acquaintances...they actually choose to avoid.*

Thus, it is important the individual has insight into their behaviour and is therefore able to make a decision to push themselves, despite initial discomfort, forward to recovery;

*Whether somebody has an insight into what's going on ...causing their symptoms.*

The ability of the individual to appraise the trauma and reappraise the trauma in an adaptive manner allows them to integrate the experience into their belief system and return to their everyday life. Jane reported that the individual needs to be able to place the responsibility for the trauma with the perpetrator and not focus on feelings of guilt or see the trauma as a personal attack;

*The blame issues... 'If I hadn't let them in, ...if I had seen the gun,...etc' which comes back to 'I could of dealt with this differently'.*

Individuals who can accept that the trauma was not a normal event and view the perpetrator as an individual offender are able to feel safer than those who generalise their fear to all individuals of the same race or gender of the perpetrator;

*Whether the person has enough experience of that ethnic background to say that individual with that background rather than all people of that background act like that...*

An adaptive cognitive appraisal of their situation allows for the maintenance of their personal cognitive assumptions as to how the world works and therefore allows the individual to regain a sense of personal control. Jane describes this schema as;

*I've met a lot of good people and I know there are people who can do things like this. The people who do things like this are not in the vast majority and generally I'm safe'.*

Jane describes psychological growth in their experience as the ability to move forward in the recovery process and not get stuck;

*A willingness to evaluate their life goals... 'I am willing to move on. I think I have choices and I am willing to make those choices'*

The concept of choice is very important and closely linked to the concept of personal perceptions of control. Jane stated that the clients that grow from the experience view their decisions as a choice they have made as opposed to being forced by the system;

*Actually seeing not returning to their old occupation as a choice they made...rather than a 'I've been forced out...I choose to go back to it or I choose not to go back to it'.*

### Key Informant Summary

Overall, for Jane recovery from trauma appears to be determined at an individual level. In her view the way in which a person chooses to view their situation and their role in their recovery will have a profound impact on the outcome. Whether others in the recovery environment choose appropriate support strategies such as recognition of the trauma and assisting the individual without overprotecting them will also substantially impact on their recovery.

### Key Informant: Beth

#### Background

Beth has a psychology degree and post graduate qualifications in social welfare, case management and client services. She has been working with stress claims for four years. Currently, she works as an injury management consultant at a large vocational rehabilitation provider in Western Australia.

#### The Recovery Process

From her experience Beth views recovery from work related trauma as a process of rebuilding and regaining what has been lost. The process of rebuilding is either facilitated or hindered by the input of the individual's personal recovery environment. Beth reported that appropriate early intervention is essential in aiding recovery;

*The ones where...I'm able to go out there quickly and get the appropriate resources happening, you trace it six months later and there's actually less occurrence of stress related injuries...*

Beth stated that early intervention needs to be appropriate and be both an active and positive approach in order to facilitate the resolution of symptoms. It is important that

the individual receives early intervention from health professionals however, it is also imperative that they receive appropriate early contact with their employer. This involves showing the individual that they are concerned and displaying a recognition that a legitimate injury has occurred. By doing this, the individual feels valued and their suffering is recognised;

*Those cases where after there has been a significant incident and management comes down and makes sure staff are okay and maybe takes them out to lunch or takes them out to dinner or maybe sends some flowers or just gives them a phone call, six months later those people are going along... are progressing.*

Beth notes the effect that a lack of recognition has on the outcome for work-related trauma;

*The people who don't get that support, build up resentment towards their employer.... 'my employer doesn't care about me' ...and that contributes to their loss of self esteem and sliding into the sick role mentality.*

The employer's support needs to include encouraging a gradual return to the workplace, that allows the individual to reconnect and reorientate themselves at his or her own pace. Beth reported that involvement by all parties in this process is important. However, this involvement or support must be appropriate. Beth reported that appropriate social support from the individual's partner is a key factor in recovery. She views this as helping the individual to normalise the situation and their feelings about it. Moreover, supporting the person in the process of reconnection, not perpetuating or prolonging their symptoms by over involvement;

*Spouses who are trying to be so protective of their spouses that they don't let the other spouse make decisions and decide for themselves...*

The spouse's protection of their partner actually reinforces avoidance, which according to Beth is unhelpful in the recovery process. This overprotection reinforces avoidance or maladaptive behaviour. Beth reported that doctor's, psychologists and psychiatrists can also overprotect their patients and not allow them to take control of their own recovery. This results in what Beth describes as the 'sick role'. This is the adoption

of a passive role in which the individual waits for a cure and this is reinforced by those around them;

*....believe that they are ill, sick and need to be taken care of and that can be reinforced by their doctors, spouses, children, but to the point where they actually don't see it as something they need to work through.*

Beth reported that in her experience this results in a loss of self-esteem and confidence that results in the individual being perpetuated in a state of learned helplessness. Thus, appropriate support encourages independence and a self-driven recovery.

Psychological intervention can be beneficial for different reasons. Beth stated that psychological intervention provides an individual who will listen and provide objective support as someone who is removed from the situation. There are positive coping strategies that can be encouraged by professionals to aid the recovery process, in particular, the provision of an exercise programme. Beth stated that this can help work-related trauma victims in a number of ways. It allows them to being to rejoin and connect socially with the world with a sense of security. It also promotes relaxation, improved sleep and establishes a routine;

*Initially, can't get out of their home and exercise is something that they can do in a fairly non-threatening environment...*

Beth also reported that an exercise programme has the secondary effect of increasing self-esteem and rebuilding lost confidence by improving an individual's self-image, which in turn has a positive impact on the recovery process.

The belief system of the individual who experienced the trauma plays a vital role in their recovery. Beth noted that in her experience individuals who experience trauma often begin to question their belief system and their perception of how the world operates. Beth expressed that those that manage to integrate the experience seem to cope better. Viewing the recovery process as a challenge is also a positive strategy. A challenge appraisal seems to reflect an inherent belief in the person's own ability to overcome, that is a self-belief in their capability to succeed,

*If someone sees something as a challenge and something they can work towards and something.... they need to try and overcome, they can view it as positive.*

Undertaking the passive role described earlier does not allow for a regaining of the perception of control. Therefore, the passive 'sick role' is reinforced and the symptoms are perpetuated. Reconciling the lack of control in the situation successfully involves avoiding self-blame;

*People try to go over what ifs, what if I had done that. They tend to deal with it somewhat less effectively than people who just accept it as fact ...that it was out of their control.*

Beth expressed that psychological issues are not well recognised or understood in the worker's compensation system. Beth reported that if an individual sustains a physical injury this often gets attention at the expense of any stress reaction;

*Physical injury and a stressful reaction ...people just tend to look at the physical injury, fix that up and not worry so much about the stress reaction.*

The non-visible nature of psychological reactions leads to a lack of recognition and validation. This type of disbelief or lack of understanding can cause both the insurer and the individual to take an adversarial stance. Beth stated that lack of understanding can lead to the insurer undertaking an aggressive claims management style that can have an impact on the individual both on an emotional and a practical, financial level;

*They [insurers] tend to handle the claim more aggressively...particularly, sort of, anti-particular worker, and sort of make life...they can make life difficult for someone who they don't particularly believe.*

Beth reported that those who are able to view their recovery as a learning experience and view recovery as a challenge are more likely to experience psychological growth. This results in a stronger self-perception and better coping skills;

*[Those who] viewed it as a challenge...at the end...they came out...glad...that 'I've dealt with that and I am moving on'... 'I'm a much stronger person'... they are going to be able to deal with it more effectively in the future.*



### Key Informant Summary

Beth conceptualised recovery as a process of rebuilding. The individual is either assisted in this by their environment or hindered by it. Like Jane, Beth reported that support needs to be active and positive as well as ensuring early recognition of the injury. Beth views the recovery environment as crucial in avoiding the perpetuation of maladaptive coping. Thus, recovery is a process of gradual reconnection to the world. Theoretically, Jane and Beth present with differing conceptualisations of recovery. Jane appears to view the process from a more individualistic level, whereas Beth's approach is more ecologically based.

### Case Study One: Simon

#### Case History

Simon is a 37-year-old male who at the time of the trauma was the manager of a retail outlet. He is married with a child and is now a landscape gardener. Simon was subject to two separate armed robberies.

During the first incident, Simon and another employee were working in the store on a Sunday night. He reported that three men burst in the doors brandishing golf clubs, screwdrivers and bricks and immediately backed the staff into a corner and ordered them to lie on the floor. Simon reported that they only needed to press one button to open the till but they attempted to open it with a golf club. As a result the till was so badly damaged they were unable to. They then forced Simon to get up and open it, but because it was damaged he was unable to open it. He unplugged the till from the counter whilst one of the perpetrators stood behind him with a screwdriver. They then left with the whole till and the police arrived 15 minutes later.

At the time of the next robbery Simon was in the back office and he heard a staff member yell, “hit the alarm”. Simon stated that unfortunately the staff member did not say whether the man had a knife or some other weapon so he felt trapped in the office, as he wasn’t sure that if he came out he wasn’t going to startle someone with a gun. He therefore remained in the office and reported feelings of helplessness and guilt, as he was unable to assist other staff members.

### Case Information

Simon was referred for vocational rehabilitation by his general practitioner. At the time of his referral to vocational rehabilitation his worker’s compensation claim was still pending, therefore vocational rehabilitation was approved on a without prejudice basis. Simon was certified as totally unfit for work and referred to a psychiatrist. His medical treatment consisted of anti-depressant medication and regular reviews from his general practitioner and psychiatrist. With the assistance of the vocational rehabilitation provider Simon chose to pursue redeployment in a self-employed capacity. At this time Simon’s claim was settled and vocational rehabilitation assistance therefore ceased. Simon was in the worker’s compensation system for a total of five months.

### Impact and Outcome

Simon reported as a result of the robberies he found that he became more aggressive and less patient with people. He also experienced difficulty sleeping, flashbacks and became increasingly socially withdrawn. Subsequently, he consulted his general practitioner and was diagnosed with PTSD. Simon felt unable to return to work at the store as he was certain that another robbery would occur. He stated that he has become more cautious about going into places such as late night chemists, video stores or using automatic teller machines. He now works as a landscape gardener and reports that his focus is now his family and their quality of life rather than money and status.

### The Recovery Process

Simon viewed the worker’s compensation system as adversarial and as a difficulty to be overcome in his recovery process. He stated that he found the legality of making a compensation claim was the most difficult part of recovery, as he believed he was met with significant opposition by the insurer. Thus, recovery was a series of challenges and obstacles that he needed to resolve and it was a process of reevaluating his life goals and

priorities that eventually led to a change in direction. Simon reported that his recovery began after consulting his general practitioner.

*The most helpful thing, I think would have been my GP... from day one just being diagnosed.*

The archival data suggests that Simon's general practitioner was a significant influence in the direction of his recovery. Throughout the file, the vocational rehabilitation provider notes on more than one occasion that the doctor believed that Simon needed to be removed from the pre-injury work environment permanently.

The role of the general practitioner was to provide Simon with informational support. This consisted of information about his condition, his progress and medication. He expressed that he found the assistance he received from his general practitioner was invaluable. He reported that being diagnosed with PTSD was a comfort as he was reassured that there was something genuinely wrong. From this point Simon was able to seek further assistance from a psychiatrist.

Simon found acceptance of his situation by others reassuring. He described this as both acceptance of the injury as legitimate and trust in his ability to recover from it;

*Acceptance is...just acceptance that this is what is happening ... that I'm taking steps to overcome it...*

Being involved in the worker's compensation system impacted his recovery. He found that being in the system meant that he had to endure frustrating delays in receiving what he thought he needed to recover, such as seeing a psychiatrist;

*There's this guy that they say can help you but it's still three to four weeks away...*

Simon found the vocational rehabilitation provider helpful in his recovery;

*It would help me to identify things that I was concerned about, as far as threatening, like, would perhaps gonna make the disorder reoccur.*

Simon reported that the time period that he had to wait before his claim was accepted was an added stressor. He found himself under financial strain and in a situation in which he was again experiencing frustrating delays, resulting in feelings of helplessness and a lack of control,

*You know, ten, eleven weeks from the day I stopped work.....so effectively three months wages...so there we are with a three month old baby...you know, I've gotta house and feed and look after...*

He reported that he received no cooperation from the insurance company. The file data suggests that there were a number of delays and difficulties with his claim. This caused a significant emotional strain. Within this process Simon believed that the insurer was obstructing his recovery;

*Deny, deny, deny ... that was their attitude.*

Thus, Simon viewed the framework of his recovery environment as hostile. He believed he had to undertake and follow-up any request that he made to the insurance company. He also saw his recovery as his personal responsibility. Simon perceived the system as adversarial and reported that he was very aware of others negative perceptions. He reported that he believed that others did not see his injury as legitimate and that he was attempting to rot the system;

*....being a workers compensation issue... we've seen the ads on the telly... you're straight away made to feel like a fraud.*

Simon stated that he believes this is particularly the case with psychological claims. As the injury cannot be seen the individual does not receive the attention or help required to recover;

*People are hurting badly...and not hurting the tangible way that the whole world can see...the whole world says "look at the poor fellow with the two broken legs". They don't know what's going on inside...*

In taking responsibility for his recovery Simon saw himself as taking an active, problem solving approach to dealing with the difficulties he faced;

*I come from a sales and management background...so I don't like to wait for things to happen...I like to go out and see what the problem is, fix it...*

He attempted to control his environment in order to limit the possibility of a reoccurrence. He reported that he became very security conscious and subsequently made a number of changes to the layout of the store. In this way he was able to increase his sense of personal control. However, despite this Simon reported that he needed to remove

himself from the stressful environment of the store and as a result he changed occupations.

*Complete...complete change away from management, away from being indoors, away from any threats.*

During his absence from work Simon found he needed to establish himself in a routine in order to feel productive and to distract himself from constant thoughts regarding the trauma. Simon described setting himself goals and undertaking physical work in order to change his focus and maintain a sense of discipline and routine. He stated;

*Well it's just ...discipline sort of thing...no matter what happens you go out there and you do the task that you've set yourself for the day.*

Simon reported that he set himself tasks in the garden to undertake everyday and he played golf with a friend every Saturday. This forced Simon to interact socially and leave the house as well as giving him an activity to look forward to that was distracting. As well as utilising behavioural distractions such as these Simon noted he used cognitive distraction;

*I guess I tried not to dwell on it...tried to focus on other things and fill my mind with other things so that... that didn't come back.*

Simon found it helpful to document his progress as he went through recovery. In this way he was able to recognise the gradual changes he had made;

*Record or document your progress so that you can go back over time and gain positives from seeing your progress.*

Recording his progress was part of Simon's sense of personal responsibility for his recovery. He reported that he believed it was his decision to recover and move forward. Thus, he viewed recovery as a challenge or a process filled with obstacles for him to overcome. In particular, he focused his anger at the insurance company;

*I'm quite determined that, you know, these bastards aren't going to get away with this...and it was obvious, you know ...virtually my sole focus...challenge towards the end.*

Simon reported a number of positive outcomes from his ordeal. Primarily, Simon reported that he has experienced a change in priorities. He reported that prior to the

incident he was largely work orientated but is now more focused on his family. From this he has noted a change in his occupational values;

*I guess my focus before was more in position and money for work,  
whereas now its got nothing to do with it...*

Simon also expressed that he has increased knowledge and awareness in regards to safety that he believes others don't have;

*....it's an insight that I have that I didn't have before, and a lot of people  
won't have.*

### Case Summary: Simon

Simon's understanding of recovery was as a series of challenges. He used distraction techniques and active coping in order to regain a sense of personal control. He viewed the worker's compensation system as adversarial and a barrier to recovery. In particular his difficulties with the insurance company became a focus for his anger. Simon also viewed removal from the environment in which the incident occurred as an important part of recovery.

### Case Study Two: Mark

#### Case History

Mark is a 48-year-old man who at the time of the interview was working part time as a driver. He reported that he had been married for 20 years with two children. At the time of the incident Mark worked for the state corrective services on the juvenile division. His job was security response at a juvenile detention centre. He described his job as "stressful". He stated that being spat on, attacked and abused was commonplace and having to respond in a professional, courteous manner was often difficult.

Mark described that he was walking around the dining room at lunchtime when a detainee attacked another juvenile with a knife. Mark tackled the person with the knife and then took him back to his cell. Immediately following this incident Mark went to see a senior officer, as he was feeling shaky. He was told to have a cup of tea and then return to duty. Following this Mark reported that he began to hyperventilate and shake.

### Case Information

Mark's general practitioner referred him to vocational rehabilitation following the trauma at work. Mark was placed on an antidepressant medication regime by his General Practitioner and was consulting a clinical psychologist. Subsequently, he was diagnosed with PTSD. He requested a transfer to a clerical position within the organisation. Therefore, the vocational rehabilitation provider developed a graded return to work programme. During this time the clinical psychologist noted a steady improvement in Mark's depressive and anxious symptoms. However, approximately two months later he was certified as unfit for work due to his ongoing symptoms. Upon being certified as fit to attempt returning to work some three weeks later Mark attempted a series of work trials internally and outside of his place of work. However, at this time his symptoms continued and his general practitioner advised that rehabilitation was not appropriate and therefore his file was closed. Mark engaged a lawyer and pursued settlement of his claim. Mark was in the worker's compensation system for a year period after which his claim was settled.

### Impact and Outcome

Mark reported that as a result of the incident he believes he lost all confidence in himself, experienced nightmares, concentration difficulties, irritability, depression and marriage problems. Although he stated he has made progress since the trauma and is currently working in a part-time capacity, he believes he is more socially isolated. A lasting result of the trauma has been Mark's self-confidence difficulties, he believes it will be five or six years before he can work with other people again and interact with them on a functional, social level.

### The Recovery Process

Mark viewed his recovery as a process that continued gradually over time. This process was helped and hindered by 'pressures' that the worker's compensation system and other contextual factors placed upon him. However, it is important to note that Mark expressed that making decisions and choices himself as to his recovery was paramount in moving forward.

The archival data on Mark's recovery suggests that control or the perception of control over recovery was a significant reoccurring theme. The initial incident report

states that the most serious type of injury caused by the assault was “nervousness and lack of control”. Mark’s clinical psychologist notes that the impact of the unpredictability of his job and the resulting feelings of lack of control. The clinical psychologist’s report stated that the obligations faced by Mark under the system compounded his feelings of helplessness and inability to cope.

The pressure to return to the workplace, take medication and conform to the goals of the system resulted in compounding feelings of helplessness and lack of self-confidence. The archival data suggests that this lack of control formed the basis for intervention from both the vocational rehabilitation provider and the clinical psychologist. The vocational rehabilitation provider suggested Mark make out a schedule of tasks to be completed during the day. This was done in order to create structure in Mark’s day and redevelop a sense of control in his day to day life. Mark reported that he believed his ability to recover from the work-related trauma was aided significantly by his personal, internal resources. He stated that his strong self-perception and belief in his personal ability to control and handle difficulties was significant in his recovery. He reported that his concept of his own strength is that it is stable and life long;

*I think emotional strength ...it’s a family trait. My mum was pretty strong, dad was pretty strong.*

Mark expressed that this strength had allowed him to be direct and active when coping with problems;

*I confront my fears, if I am scared of something...I mean I am terrified of snakes...I confront them.*

Although he describes an active, confronting style of problem solving he also reported needing to detach himself from his situation in order to cope. He reported needing space away from his daily life and the people around him;

*I think what I did is I ..um.....I guess part of me detached a bit...from the world.....*

He stated that he needed to detach mentally from himself as well as the environment around him;

*From my thoughts and the world in general.*



Mark received some support from within the system to pursue 'removal' as a coping strategy. In a memo to Mark's employer the worker's compensation officer within his organisation notes that Mark's doctor believed that it was inappropriate for Mark to return to his pre-injury workplace. Thus, the general practitioner certified Mark as unfit for work and as unfit to return to his workplace but fit to undertake rehabilitation at another institution. Thus, supporting removal from the original workplace and any reminders or triggers of the event. Mark's clinical psychologist gives support to removing Mark from his original workplace. She suggests in a phone call to the vocational rehabilitation provider that Mark take at least two weeks off. In a later report she suggested that he take an extended holiday.

The focus and obligation to participate in vocational rehabilitation was perceived by Mark as a stress in itself that he believed he needed to remove himself from in order to recover. The archival data suggests that Mark tried a number of avenues to remove himself for the situation; redeployment, considering resignation, taking leave without pay and at his most desperate, the ultimate removal strategy, contemplating suicide. Mental detachment required a component of distraction from his thought processes. This was achieved through undertaking tasks that he needed to concentrate on but were not mentally complex;

*I think....simple, physical work. Simple, simple but basic physical work tasks are what you need.*

He described the process of detachment as necessary in order to rest and heal mentally.

*If a muscle is injured, you rest it. If your head is injured, like your soul and your spirit and your emotions and your mind, you rest them...*

Mark's recovery was largely constrained by the worker's compensation system and help available and provided within this. Mark did not feel able to undertake what he thought was necessary to help himself because of the pressures the system placed upon him;

*I felt I had to go on the antidepressants just to jump through the worker's compensation hoop. If I didn't, well then people would say 'Oh, there's nothing wrong with him, he's just hamming it'....well, I wasn't.*

Thus, Mark felt compelled to undertake treatment he wasn't comfortable with in order to show cooperation and a willingness to recover. In order to legitimise the injury and continually prove his validity to others in the system. In this way control was again taken from Mark, placing him in a powerless position and affecting his recovery. Mark viewed his recovery as a process in which he needed to reconnect at his own pace and make decisions to regain a sense of control. The worker's compensation system and other environmental factors within his recovery environment were seen as pressures to be overcome before recovery, rather than aids in place to assist him.

Mark viewed the worker's compensation system as adversarial. He believed it placed pressure upon him by the stigma associated with stress claims and being on worker's compensation;

*...the thing of surveillance...I felt that the insurance company was looking for an excuse not to pay.*

Mark attempted to return to his workplace with the assistance of vocational rehabilitation. He reported finding vocational rehabilitation helpful, however, limited by the system. Returning to work was an important part of the recovery process. However, the process of returning to the workplace was made difficult by a number of factors. Firstly, Mark reported that he was constantly aware of his coworker's perception of his situation. He believed that they did not believe his injury was legitimate and that somehow they perceived him as 'weak'. This impacted greatly on his self-esteem and ability to reintegrate with the workforce.

*"Oh are you going to fall in a blithering heap again, are you*

*[Mark]?"...devastated. The fact that I'll be the butt of people's jokes.*

The impact of this was compounded by his perception of a lack of support from his colleagues upon returning to the workplace. Mark reported that whilst trying to return to work on alternative duties he believes that he was seen as a burden and an annoyance, as such his colleagues were not willing to assist him in learning the tasks necessary to undertake the occupational role;

*'We sort of have to look after this...this sort of cripple'... so to speak. You see yourself as a bit of a lame duck...and I just didn't feel supported there.*

Mark expressed that support from his employer was mixed. Due to the adversarial perception of the system Mark viewed his employer as against him in the process and therefore the employer was seen untrustworthy. This culminated in feelings of betrayal from actions undertaken by his employer during the return to work process;

*They said we'll put you with the prison department, working in a store situation and that was a false promise...I got shafted there.*

The decision not to continue in his pre-injury role greatly assisted Mark's recovery. Through that decision he reported regaining a sense of control as he was ensured that he was removed from the stress of his workplace and tangible reminders of the event;

*I think the decision... when I knew for certain that I was never going back to that.*

Mark found some professional support helpful. In particular, one clinical psychologist. He reported that he perceives the role of psychologists as to listen not to solve problems. He stated that it was his responsibility to recover from the trauma. However, he noted that a number of mental health professionals were not helpful. If he had to give advice on what not to do, he recounted the following;

*Don't be so achievement orientated....advise them [psychologists] to be patient.....and they think they are not on the right track if they don't get instant results, if they are not the cure.*

However, he noted that there were individuals in the system that he believed were helpful in moving him forward in the process. In particular, his superintendent was seen as supportive as he sent him a letter of commendation. This action was perceived as acknowledgment of the injury and legitimisation of the subsequent stress and suffering that had occurred. Individual attention and recognition of the injury appeared to be crucial in order feel supported:

*Perhaps I feel that there should be something more....a bit more focused on the individual worker.*

Mark had a physical shoulder injury from a similar incident that occurred around the same time as his stress claim. He felt that his shoulder injury received greater

attention due to its tangible nature. He reported that because it was concrete and visible he received more feedback and could more easily monitor his progress;

*I think it's easier to measure.....I mean something ..I mean I could give feedback 'yes it's sore, no its not' ....what was going on in my head was just a misty cloud to me.*

Outside of work, professional and system supports Mark reported that he found one of his greatest sources of support was talking to people outside of the system. He stated that he needed to be listened to by people who understood and were not going to judge him;

*Talking to people who ...who helped me ...understood....who actually had sympathy. I felt were empathising. Not yeah, yeah, yeah but people who weren't paid by the insurance company.*

This support came from a number of sources. Mark reported that mainly this support was from friends;

*Being able to talk to people who just hear you and don't criticise you for your actions ...people who I felt accepted me.*

Mark gained this type of support from a pastor at his local church. He believed he related to the pastor because they had similar backgrounds and therefore he felt understood. Mark presented with strong spiritual beliefs and drew upon support from this pastor in his recovery as well as other spiritual support. However, he was careful to point out that he did not see religion as a cure for all his difficulties;

*I don't see God as a rabbit's foot, maybe there were some people praying for me....*

Mark found he was unable to draw on this type of support from his wife and family. He stated that the trauma and its after effects put pressure on his marriage;

*It stuffs up your marriage...because I wasn't the man my wife married. I'd changed...I'd fallen in a heap.*

Mark found that his wife was too close and involved in the situation to be able to provide the type of support that he felt he needed;

*She didn't know how too...maybe she meant well....possibly too close and too tied up with it.*

Mark reported that although he believes he has recovered from the trauma, he does not think he will ever return to being the individual he was before the incident. He expressed that going through the trauma and recovery did lead to some positive consequences. He found through facing the aftermath of the trauma he was forced to deal with a number of issues that he had been denying;

*“I can say something positive has come out of it and that’s it took the scab off a whole lot of old wounds that needed to bleed....I guess it blew the lid off everything”.*

### Case Summary Mark

Mark’s experience of recovery was strongly affected by his involvement in the worker’s compensation system. Like Simon, Mark saw the worker’s compensation system as adversarial and believed his situation was made worse by his treatment in the system. He believed he needed to remove himself from work and people in order to heal. Thus, vocational rehabilitation and those in it were viewed as stopping him from doing what he needed to recover. He found the system and some professionals unhelpful, his family was too close and in general he reported he felt that he was not understood. Thus, recovery was a personal process that involved detaching socially and emotionally and slowly rejoining in his own time.

### Case Study Three: Luke

#### Case History

Luke is a 47 year old married man with five male children. He reported that at the time of the incident he had been working in juvenile justice for 23 years. Luke had been supervising a young man and he had picked him up from his mother’s house. As they were driving along Luke recalls they were having a normal conversation, the young man was asking him what he liked to do in his spare time when suddenly he swung around and hit Luke. The juvenile started screaming and hit Luke repeatedly until he was forced to stop the car.

Luke recalls very little about getting out of the car except that he was stuck by the seatbelt and as he was getting out the juvenile was still punching and kicking him. Luke reported that he had stopped the car in the middle of a busy highway in peak hour traffic.

Luke was dragged backwards and forwards across the highway several times. He telephoned the superintendent to request bail be withdrawn on the young man. To his shock his workplace was not aware that he was signed out with the juvenile. He was taken to hospital and discharged at seven o'clock that night. Since that time he has suffered from debilitating headaches.

#### Case Information

A psychiatrist saw Luke following the incident. He was diagnosed with PTSD and placed on antidepressant medication. However, from the archival data it appears that Luke developed a number of side effects from the medication and his medication regime did not settle for a number of months. Luke referred himself to vocational rehabilitation three months after the assault. Initially, a transfer and graded return to work programme was attempted. However, Luke experienced an increase in symptoms and was unable to continue. During this time the insurance company sent him for three separate psychiatric reviews. All of the psychiatrists agreed that he was suffering from PTSD and was unfit to return to work. As he was unfit vocational rehabilitation was viewed as inappropriate, and his file was closed. Luke then sought a settlement of his claim. Luke was involved in vocational rehabilitation for nine months.

#### Impact and Outcome

Luke eventually resigned from the department following his attempted return to work. He reported that he has experienced marriage difficulties, loss of self-confidence, depressive symptoms and suicidal thoughts. He still experiences headaches and some anxiety symptoms. Further, he stopped being active in his community and withdrew socially. At present, Luke considers himself retired and does volunteer work when possible to help others in his community. He reported that he is starting to rebuild his confidence and is considering returning to the workforce in a different capacity.

#### The Recovery Process

Luke stated that throughout his recovery the most helpful support he received was from one of his sons and a close family friend. He found that their ability to listen without giving him advice allowed him to express what he was experiencing without fear of censure;

*Whether I was right or wrong, they were prepared to listen.*

Luke found that he was able to get this support from his partner initially. However, she was too affected by the event to be able to remain at a helpful distance and began giving him advice and this resulted in conflict;

*[S] started saying 'no, that's not right' ...I can remember one time saying to her, "it doesn't matter whether its right or whether its not right, this is how I am seeing it'.*

Luke was referred to a psychologist for counselling by his employer. This was not a helpful experience as the psychologist did not turn up to the first three appointments. A later psychological report notes the unprofessional conduct of the first psychologist.

Luke reported that when he did see a psychologist he did not feel understood and felt that they did not address the full impact of the trauma on those around him;

*He never once sat the whole family down. There was no-one who sat the whole family down and said, 'look you know, this is the situation'.*

Thus, Luke reported that his personal situation and the impact of the trauma on his own unique context was ignored. It is of note that in an assessment report by a clinical psychologist, counselling with Luke and his partner was recommended with the aim of assisting the family to deal with Luke's condition. However, this did not eventuate.

A significant impact on Luke's recovery was the perceived support from his employer. He stated that from immediately after the assault he did not feel supported by his employer. He believed that they should have been more overt and active in supporting him from the beginning. When asked what he would have liked the employer to do, Luke was clear;

*Well, one... the employer insisting that I had stayed in hospital....I would have had people coming around to see how I was handling it and how the family was handling it.*

Luke formed the impression that neither his employer nor his coworkers would support him. He believed that no one at his workplace wanted him to return. Further, he believed his coworkers thought his claim was not legitimate and that he was trying to rot the system;

*The distinct impression I had is, [Luke] is not here, [Luke's] going to take it full mileage...*

Luke found it difficult to return to his workplace because of this perceived lack of support. The psychiatrist noted that he experienced considerable anxiety symptoms upon seeing work colleagues. Luke expressed that whilst he was attempting to return to the work place he needed to see a visible show of support from his employer. He stated he needed a safety net of support that he could fall back on if necessary. He interpreted the lack of resources and support that he received as an indication that he was not valued;

*If they had a person there, just staying back, just in case you needed it...I don't think I would of needed it...but I feel it was the fact that they didn't trust me in that position.*

He saw his employer as trying to do as little as possible within their obligations. He describes the example of the day he resigned;

*The lawyer of the department said 'you need to just put down I resign as of today'.... All right.... So I put down 'I resigned today'. As a result of that, I lost about eight thousand dollars because they didn't pay me my holidays, long service leave and all that, because I resigned.*

The reaction he received from his employer and coworker had a devastating impact on his recovery;

*There is no animosity against the kid at all. Whereas initially, you know, was like, 'how could he do this to me?' You know.....it more changed to how much the department has let me down. How much the department has done.*

It is of note that a clinical psychologist report suggests that Luke's perception of his employer was a significant impediment to his recovery.

The support that he received from the vocational rehabilitation provider was positive. However, he found that the progress moved too slowly and this impacted on the dynamics of the workplace. As he was doing a graduated return to his workplace Luke believed he was perceived as a nuisance by his coworkers, as a result he felt unproductive and this impacted on his self-esteem;

*All I wanted to do was get back.... 'let's go slowly.. half a day' and because I get to do half a day it was 'oh well what can we find you to do' ..It was demoralising.*



Luke felt that the stigma of being on worker's compensation impacted on the level of treatment he received. He felt that the professionals he consulted in the medical profession assumed his injury was not legitimate and treated him accordingly. Moreover, he felt that because his headaches didn't improve the doctors became frustrated and started to suggest that he was malingering,

*One of them basically told me that I couldn't be getting headaches. That there was nothing wrong with me....*

It is noted in a psychological report 15 months after the assault that Luke's headaches were only beginning to be treated at that time. As headaches were not visible or tangible, Luke felt that no one believed him and that the people he dealt with became increasingly hostile. He expressed that the physical scars were a constant and instant reminder to him of the trauma;

*Every time you have a shower and looked at your back, the bite marks were there. It was like an instant reminder of being almost mauled...they couldn't cover it up, but it just increased how I felt inside.*

Luke viewed his recovery as a process of constant self-evaluation. He found that initially after the trauma he wasn't able to do this effectively as he had a number of environment pressures consuming his time and capacity. However, as the process continued he found he was able to take stock of what had happened and begin to evaluate his role and needs. From this point he began to make positive cognitive appraisals in regards to the situation;

*When I had the incident, I had everyone knocking me down, I didn't have a chance to...to say 'Look here – I did very well, I stopped the car. I didn't cause damage to the car' ...I remember thinking 'gee I could have swerved in that car. I could have killed somebody'.*

Luke reported that he then began coping with the trauma by using familiar coping strategies. He described his process in four steps. Firstly, making the decision that recovering was his responsibility. Secondly, analysing the problem and recognising his reaction to it and then removing himself from the stressful situation in order to be calm enough to solve the issue. Luke viewed his recovery as a challenge and a process of regaining what was lost:

*I hit the bottom, rock bottom, I then started trying to climb back out and I feel like I'm getting better and better at it.*

At what he describes as his lowest point he took responsibility for his recovery and made a commitment to getting better. He also made a tangible commitment to his wife;

*The only other one thing I did was buy [S] - a new car and that was because that was part of my 'okay, I'm not going to leave [S]...to make her feel good I'll get her a car', and it did make her feel good.*

Seeing the process as a challenge meant that difficulties were obstacles to be overcome,

*At first it was little things...little pebbles I was jumping over...whereas now I feel like I'm going over boulders.*

However, an assessing psychologist noted that Luke coped by withdrawing and when faced with conflict he would 'explode'.

On a community level, Luke expressed that he would have found it helpful to have talked to people who had experienced something similar;

*...it would have been good if people had of said 'look, here's a group that you can go to...they can help you...they have experienced the same sort of things'..*

Luke expressed that although the trauma has had a significant negative impact on his life he has started to change the way he thinks about it. He used to view the results of its occurrence as only negative but is beginning to see some positive outcomes. He used to view being retired as meaning he was no longer useful however he now views it as an opportunity;

*I'm starting to ..to think of myself now as ..lucky, you know. I'm retired and I'm still young.*

He expressed that being retired has allowed him to help others and this is how he has found meaning in what happened to him;

*I enjoy doing things for people, I enjoy helping people and this is giving me the perfect opportunity just to be able to help people.*

### Case Summary: Luke

Luke viewed his recovery as a series of challenges and obstacles that he needed to overcome. He also believed that he needed to 'hit rock bottom' prior to making significant gains. From this point it was a process of overcoming difficulties by analysing the problem, recognising his own reaction to it and removing himself from the situation in order to give himself enough distance to calm down and solve the issue. Like Mark, Luke experienced marriage difficulties and found his family was too close, except for his son and therefore unable to be of assistance. He found his friends to be a good source of emotional support whereas he did not feel listened to by professionals. He believed that discussing his situation with others who have experienced similar trauma would have helped. It appears that the most significant impact in Luke's case was the actions of the employer. Unlike Simon who found his treatment by the insurer a focus for action and anger, Luke's perception of his treatment by his employer appeared to compound and exacerbate his situation. Like Mark and Simon, Luke was profoundly aware of the stigma of being in the worker's compensation system and felt that he was treated differently due to this. He also saw a delineation in the treatment of injuries that could be seen and the less tangible, psychological problems he experienced.

### Case Study Four: Paul

#### Case History

Paul is a 37-year-old accountant. At the time of the incident he was the business manager for a large auction house. Paul was assaulted when banking the day's takings. As he was placing money in the nightsafe, he was disturbed, as he turned around he was hit hard on the right side of his face with a knuckleduster, he resisted, yelled and chased after his attacker. The attacker ran back and hit him again and as a result Paul collapsed. When he arrived at the hospital he could sense that some of the people there looked "queasy" when they looked at him. Paul underwent extensive cranial reconstruction, half of his eye socket was missing, his cheekbone was shattered and his other cheek was dislocated. He also suffered extensive lacerations.

### Case Information

Paul was referred for vocational rehabilitation two months after the assault. However, prior to being referred he returned to work on his own volition undertaking clerical tasks. The insurance company referred him to vocational rehabilitation to assist with the return to work process. A graded return to work programme was developed and Paul gradually increased his hours and tasks. During this time he was referred to a clinical psychologist. Despite this, he continued to report both physical and psychological difficulties, most notably concentration difficulties. Paul continued to improve and six months after the incident he was undertaking full time hours, and he reported he required no further assistance. Thus, the case was closed. However, Paul reported he needed to change environments and he redeployed himself. Paul left the company and went to work with a previous employer in a position that was less financially and analytically orientated. Paul was in the worker's compensation system for six months.

### Impact and Outcome

As a result of the attack Paul suffered a number of physical and psychological difficulties. The viciousness of the attack meant that Paul needed extensive bone grafting and as a result was left with permanent scarring and nerve damage. For a number of months Paul's face was completely numb, his speech was slurred, his eye was extremely sensitive and had excessive discharge. Paul expressed that he still experiences pain when the weather changes and his eye is now more susceptible to infection.

Following the trauma, Paul experienced symptoms of depression, nightmares, anxiety, feelings of extreme anger and panic, memory difficulties, and apprehension when around other people, particularly strangers. He believes that cognitively his reaction time is slower and that this may be due to the head injuries he sustained during the attack. He stated that as a result of the trauma he and his wife are not as socially active as they were previously. However, he noted that he believes that they have a more emotionally close and fulfilling relationship.

### The Recovery Process

Paul viewed his recovery as a process or journey that he had to undertake on his own with the help of his wife. He initially sought support from professionals in the mental health field but found their response unsatisfactory. As a result he viewed himself

as responsible for seeking the means necessary to overcome his difficulties and rebuild his life. Paul stated that the most important aspect of his recovery was the support he received from his wife. This was apparent from the time he was in hospital;

*My wife stayed there for two nights and that meant a great deal to me.*

The role of Paul's wife was initially to listen and provide emotional support and later on provide feedback. He viewed her as going through the process with him, noting that recovery for him was 'a team effort'. The support he received from his family and close friends was similar to the support he received from his partner. He expressed that listening and understanding were paramount. However, the difference between his friends and family was that from his family and partner after some time he wanted feedback;

*The people I was closest to were my parents and R---[wife], I wanted feedback...I wanted reaction.*

Paul reported that the support that he was most comfortable with and found the most beneficial came from people who knew him prior to the incident;

*I felt more support from the people that knew me, the old me, than total strangers trying to in my opinion, treat me like every other Tom, Dick and Harry and not treat the person individually and say 'okay what is that person's background'.*

The recognition of individuality was lacking in the treatment that Paul received from most of the health professionals he dealt with. Soon after the assault he was referred to a clinical psychologist for counselling. Paul stated that this experience was particularly unhelpful. He reported that he did not feel that he was treated as an individual with unique experiences and concerns but rather as a group of symptoms. As a result, he felt that he was not listened to, respected or given the help that he needed;

*Each person is unique... ..it was let's get this person to what we think he should be.*

Paul stated that he felt he needed his story prior to the accident to be listened to and considered in light of the resulting impact of the trauma. He wanted his personal context to be reviewed in order to develop a clear picture of who he was and an understanding of the extent of the impact the trauma had had. Paul expressed that he did not find the services of a psychiatrist any more helpful than the clinical psychologist;

*Neither the clinical psychologist or the psychiatrist said..... 'tell me your history'. They just treated you like a .. you know any other....*

Paul reported that he did receive positive professional support from his general practitioner. He noted that he felt comfortable with his doctor because he knew him prior to the incident and felt assured that he took into account his unique context;

*He knows my history. I had to go to someone that knows me, before the event.*

In a report the general practitioner stated that he had no doubt that Paul's symptoms were accurate and correct. This type of support counterbalances the legitimacy issues that Paul faced. When dealing with his general practitioner he felt that he was believed and respected. The support that he received from the general practitioner was different from that of his friends and family. The general practitioner gave him medical and clinical information on a factual basis, moreover he provided a professional opinion that in Paul's appraisal did not contain an emotional investment in his situation;

*That support was basically from an outsider. He's not a family, he's not my closest friend... the clinical side ...information from the doctor.*

Paul reported that he found vocational rehabilitation helpful. He found the structure and gradual nature of the return to work programme allowed him to slow down and recover at an appropriate pace;

*That was very helpful...that was very positive...it was structured...very basic, gradual steps.*

The archival data on Paul's recovery shows that a number of people around Paul wanted him to slow down his efforts at recovery to avoid frustration. In discussions with the vocational rehabilitation provider Paul's general practitioner advised the vocational rehabilitation provider to limit the hours of Paul's return to work as he believed he would be likely to do too much.

Paul's return to work was facilitated by a strong commitment by his pre-injury employer. The employer provided practical support by offering to continue to pay his wages when the insurance company refused to. To Paul this showed him that he was valued and believed by his employer. Having the financial pressure relieved meant Paul was able to pursue the self-paced recovery he needed;

*I spoke to the proprietor and was very grateful that he said 'ok come in, go into your office and just do anything, just do nothing just do what ever you want' ...it was very relaxing.*

The vocational rehabilitation provider also noted the employer's willingness to support Paul and accommodate his return to work in a number of reports.

Despite the support of the employer after returning to the office Paul decided he needed to remove himself totally from that particular work environment. He expressed that the location of the office reminded him of the event and the pressure of his occupation meant he wasn't able to recover further whilst staying at the same employer. Paul expressed that his new employer was also extremely supportive;

*There at the new job, they knew of what had happened to me. So, they were extremely supportive as well.*

Working was a distraction strategy in order to assist in avoiding constant thinking about the assault;

*I had people walking around. There was a lot of activity...looking at people moving, people laughing, crying...that got my mind away from it.*

Paul expressed that the type of support that he felt would have been most helpful would have been talking to a person who had been through something similar. He stated that this would have been particularly helpful immediately after the trauma, in hospital;

*...to me talking about it to people that you could relate to would be far more helpful than someone you go visit....saying 'ok, how do you feel'.*

A perceived lack of community support had a large impact on Paul. The assault was witnessed by a number of people and occurred in daylight. He was shocked that no one would come forward to help police;

*The person...that was doing the ATM saw everything and refused to get involved and that hit me ...when I sort of get that reaction ...that hit me, that hurt.*

The impact of this was a questioning of his personal belief system and view of others as basically good;

*Someone said it was this person ...no-one there, my fellow man, didn't want to help me.*

The clinical psychologist notes in a report to the doctor that Paul was surprised by the viciousness of the attack. This lack of support was also perceived on a wider societal level. Paul felt that the court system and society in general let him down by not placing responsibility for crime with the perpetrator. Thus, again Paul's beliefs and value system were thrown into question;

*The community is there to blame for this happening, not the person who caused it. I felt the law had let me down.*

Paul placed the responsibility for the attack with the perpetrator and the responsibility for recovery with himself. He stated he had always had a strong self-concept and believed in his internal resources and willpower. This positive appraisal of himself and his determination meant he believed he had the ability to recover;

*I have always had this will power that ...don't let anything get you down.*

Paul found aspects of the worker's compensation system both helpful and frustrating. Initially, he believed that everything was moving too slowly and he wanted to see quicker results. However, Paul also expressed that support such as vocational rehabilitation was helpful in slowing him down in order to facilitate recovery. Paul was aware of the stigma of being on worker's compensation and the perception of others towards him. He viewed the insurance company as wanting to stop his payments as soon as possible, whether he was recovered or not;

*...the insurance company technically thought I was back at work.....and straight away I lost everything....and that hit me.*

Thus, although he was back at work undertaking full time hours Paul did not feel he was back to undertaking his job in a fully competent manner. Thus, he felt his injury because it was not tangible like a broken leg was not being legitimately recognised within the system;

*I was on my own. ...and it's a catch 22. If I don't get back to the office, I wasn't going to get well.*

The insurance company had the financial power and influence to be able to move Paul in certain directions to achieve an outcome that on the surface looked acceptable. However, this was not truly indicative of his real recovery status.



Throughout Paul's recovery he was aware of the differing treatment and reactions he received due to his psychological injuries and his physical injuries. He expressed that he understood that there was a limited amount that could be done to treat his physical injuries but when it came to dealing with the psychological impact of the assault he found his treatment to be inadequate. He expressed that he felt that the professionals he dealt with were wanting to deal with him too quickly and in what he felt was a dismissive manner;

*Psychologically, I think the emphasis there was...get it done straight away. Lets get him back on his feet straight away ...lets close the book.*

As a result of this he felt that his aims for recovery were different from those seeing him;

*They weren't doing anything in terms of that persons...let's get that person doing what he was doing before... it was lets get this person to what we think he should be.*

Paul also experienced a lack of recognition of the existence of his psychological difficulties. It is of note that there is no mention of psychological symptoms on his initial accident report, his first medical certificate, progress medical certificates or any medical report for the first three months after the assault. The psychological impact of the trauma is first mentioned by his reconstructive surgeon in a report to the vocational rehabilitation provider in which he stated that Paul had physically recovered but was suffering a severe stress reaction as a result of the attack.

Paul was strongly affected by other people's reactions to his physical injuries. He reported that in the hospital people requested he be moved out of sight;

*...they had to close the blinds...and that sunk in. that really hit me hard.*

Paul felt isolated and shut off by this reaction. As his recovery progressed he also saw the physical scar as a constant reminder of the assault. He found pain or the reaction of other people were a stimulus for ongoing anger in regards to the trauma. However, the physical healing process was important to Paul as it was a tangible display of recovery and provided a framework that influenced his mental recovery.

As a result of experiencing this trauma Paul reported some areas of psychological growth within his life. Firstly, he believes that he has changed his life priorities. Prior to the assault he reported that he was a self confessed workaholic and everything else came

second. When this occurred it caused him to reassess what he valued and as a result he now places more emphasis on his relationship and family than his career;

*I started thinking...well I got support from my wife...maybe I made a mistake here. I should look after my family, my wife.*

As a result of this change and his need for support Paul has experienced a change in his marriage. He believes that he and his wife now have a closer and stronger emotional relationship. Finally, Paul believes that through his experience he can help others and therefore he has experienced growth through learning. He reported that he hopes he can create better understanding of how to deal with individuals who suffer a trauma particularly mental health professionals;

*I could change, for example a way this person would treat people like myself, I feel ...um .. I've contributed something out of it... You need to make sure in my view...make a positive contribution and learn from this lesson.*

#### Case Summary: Paul

Paul's recovery environment was very different due to the types of positive support he received. Unlike Mark and Luke, Paul found the support of his wife and employer invaluable. However, like Mark and Simon, Paul found the services of the mental health profession were lacking, resulting in feelings of mistrust. An important aspect for Paul was having people around who knew him prior to the trauma, as he felt understood and respected by these people. He also felt believed, as these individuals did not question the legitimacy of his injuries.

Paul found it useful to be slowed down whereas Luke was frustrated at not being able to go faster. Like Luke, Paul found the physical scars triggered memories of the trauma. Like Mark and Luke, Paul perceived a lack of appropriate focus on his psychological symptoms as opposed to the physical ones. He believed that this may have been helped if he had been able to talk to others with similar experiences. Like the other participants, Paul perceived that he was manipulated in the system to his detriment and did not view his overall experience with the worker's compensation system as helpful. Finally, Paul appeared to have different psychological gains than the other participants.

He found the incident not only changed his focus like Simon and Luke but also created a stronger and closer relationship with his wife.

### Case Study Five: Mary

#### Case History

Mary is a 51-year-old woman, married with three grandchildren. At the time of the interview she was employed as a receptionist by a medium sized business. Mary reported that twelve years prior she was present during an armed robbery at her place of work. At the time of the incident Mary was a Bank Teller at a neighborhood branch. She was serving a customer and as she looked up she noticed that two young men had come to the back entrance of the bank. They both came inside the bank wearing balaclavas and carrying shot guns. Mary reported that they both started shouting and demanded that everybody lie on the floor. Everybody in the bank, both staff and customers, did as they were told. However, Mary froze and was unable to lie down. She reported that she was the only person in the bank who remained standing. One of the perpetrators then approached Mary and placed the barrel of the gun to her neck and demanded that she fill bags with money. She proceeded to give him all the money that was available in the draw and the perpetrators then left.

#### Case Information

Mary returned to work the day after the hold-up and attempted to continue as a teller. However, she was unable to do so and she was certified as unfit for work two weeks after the incident. At this time she was referred to a psychiatrist who diagnosed her with PTSD. Mary participated in a graded return to work programme and slowly built up her hours and time dealing with the public. She also continued with counselling and hypnotherapy. Upon successfully returning to full hours and duties her rehabilitation ceased. Mary remained a teller for 18 months. However, due to changes in the bank she was relocated to an administrative position in which she remained for five years.

#### Impact and Outcome

Mary reported that she was “*a mess*” for approximately twelve months after the robbery. She recollects feeling extremely angry and vulnerable. She stated that she felt like her senses were incredibly acute, her heart was constantly racing, she experienced panic attacks and became frightened to leave her house. Mary’s distress also had a large

impact on her family; she was constantly crying, didn't want to go anywhere and was unable to focus on the problems of her children. She stated that she felt that the perpetrators had taken away her self-esteem, her confidence and she felt consumed by a terrible feeling of vulnerability. She reported that over time she recovered more fully. However, to date she still sometimes has flashbacks or anxiety when in a stressful situation and does not trust people as much as she used to.

### The Recovery Process

Mary conceptualised recovery as a process that she moved through. The process has facilitating and inhibitory factors analogous to a game of snakes and ladders. However, unlike snakes and ladders, Mary suggests that she needed different sources of help at different stages in the process. Different groups of people and strategies provided her with different sources of strength to recover.

Mary's reaction to the robbery was to withdraw, she did this socially, emotionally and occupationally in order to attempt to cope with impact that the trauma had on her life. The process of recovery was to reconnect to herself and her life and attempt to integrate the incident into her experience in order to be able to effectively function and continue with her life. The process of reconnection involved rebuilding her self-esteem and sense of control by utilising different resources at different times. Mary reported that at first her immediate family was the most important support and most of all she needed them to provide a safe and protective environment.

The perceived support of her employer was a crucial factor in recovery. The importance of the employer was not in their actions but in Mary's perception of their support. In order to feel supported, Mary expressed that she needed them to acknowledge that she had suffered a legitimate injury and validate that although the injury could not be seen it was recognised by them;

*I would have liked more...sympathy, understanding and concern by the bank.....They didn't really give me attention.*

Mary reported that she found psychological intervention useful, particularly hypnotherapy as it enabled her to relax and escape the anxiety that she was suffering. However, she noted that she needed a longer intervention but felt unable to ask due to contextual influence of the worker's compensation system. Mary reported that she was

concerned about the stigma of being on worker's compensation with a psychological injury, as a psychological claim is not tangible or visible she was concerned about what her coworkers and employer would think of her;

*I didn't want to make a fuss, I was on worker's comp...This worrying about what other people think was a big mistake with me...*

The outcome of this was a lack of communication between all of the involved parties resulting in Mary not getting the intervention that she felt she needed. Mary expressed that the lack of communication between the psychologist and the employer left her feeling distrustful. She would have a session with the psychologist and then go to work and nothing would be said. This compounded her perception that the employer was not supportive and did not recognise her injury as legitimate;

*Maybe if the three of us got together.....I felt I was kept in the dark, I didn't know what was going on between the two of them.*

The psychologist's role was also to legitimise the injury and provide informational support and reassurance to Mary. In this way the psychologist aided Mary in appraising the situation as manageable and therefore aiding the process of regaining a personal sense of control.

Mary stated that positive support from friends was the most helpful element in her recovery. The role of friends was different from that of family, psychologists and the employer. Positive support from friends entailed listening in a way that family and others could not. Mary reported that she believed that family is too close and therefore they suffer with the individual and are unable to listen in a useful way. Mary describes helpful support from friends as follows;

*Being able to say anything and everything that you want to say....family.....they are too close and too involved ...*

Friends were unhelpful if they made light of the incident or suggested that it was exciting or an adventure. This entails a devaluation of the emotional impact of the trauma and promotes the notion that the injury is not legitimate or real.

The vocational rehabilitation provider worked with Mary to develop and implement a graded return to work. This involved Mary returning to the workplace on reduced hours and days and undertaking different duties other than serving on the

counter. Over a course of weeks, Mary gradually returned to full duties and full hours. This was a positive process for Mary as she perceived this intervention as an indication that her employer believed her injury was legitimate. Further, she expressed that it provided reassurance for herself that her symptoms were real and allowed her time to process what had happened and start to recover;

*When I did go back, it was only a slow process – so I felt they [employer] were understanding of what was happening...*

Mary expressed that ultimately the responsibility for her recovery lay with herself. Within the recovery process, support from other sources such as friends and family were a necessary but not sufficient factor in overcoming her traumatic experience.

The importance of internal resources such as coping strategies, cognitive style and mental appraisal of the situation were integral in mobilising other resources and using them in the most effective manner possible. Mary expressed that, to her, recovery was a choice, she needed to decide to recover and regain control. This involved not giving into her symptoms, maintaining a positive focus and viewing the situation as a challenge rather than an affliction;

*I think you can let your mental inadequacies take control. I wanted to be in control. I wanted to get over this and I did and I think I did it well.*

Mary was able to make sense of the event for herself by redefining the event and finding meaning in its occurrence. Mary explored the consequences of what had occurred and concluded that she was lucky to be alive, as both of the perpetrators were armed. Mary stated that she was lucky not to have been shot. She also expressed why she believed she was targeted;

*It happened to me because I didn't hit the floor. If I had hit the floor.... They would maybe put the gun on to one of the customers.....I'd like to think that picking on me saved someone else.*

Mary utilised a number of coping strategies to facilitate her recovery. Primarily, Mary used removal and distraction in order to cope with the initial impact of the trauma. Distraction involved going on holiday, swimming, relaxation and walking on the beach. In order to reconnect Mary initially needed to disconnect to absorb the impact of the trauma. During the process of reconnection she started to utilise more cognitively

engaging strategies. These were self nurturing 'building' activities such as positive self-talk, going out more often with friends and focusing on herself and her own needs.

The interaction between the factors in Mary's recovery, her influence on the environment and its subsequent influence on her combined to form a platform for psychological growth. Mary reported that as a result of the trauma she now perceives herself to be a stronger person, with more coping strategies to handle difficult situations. She also stated that her attitude to difficulties has adjusted in that she no longer worries about issues she has no control over. The resulting outcome of this acceptance and her reappraisal of herself, her strengths and limitations resulted in a greater appreciation of life and awareness of her fortunes. Mary stated that she is now more likely to undertake activities that prior to the trauma she would have been afraid of doing;

*Just doing things that you would normally be afraid to do....going ahead and doing it ...doesn't matter how scary it is – just go ahead and do it.*

The rebuilding process for Mary culminated in not only a return to feeling confident and competent but moving one step beyond this to psychologically flourishing.

#### Case Summary: Mary

Mary discussed recovery as a process of rebuilding strength to regain control, self-esteem and self-worth. To be able to do this, she stated that she needed to be given the opportunity to make decisions on her own, no matter how small, without reprisal. Thus, the strength to regain control came from acceptance from family about decisions that she made. For example, going on holiday, listening from friends without judgement to whatever she chose to say or not to say and reassurance and validation of the emotional impact of the trauma from her employer.

Interestingly, Mary found the support of her family helpful initially but like Mark and Luke she found that she needed support from her friends as her family was too close. Mary's recovery was task focused using physical activity and distraction as a means of coping. Mary grew from the experience noting strong psychological gains. These were more internally focused gains than described by the other participants, including a stronger appreciation of herself and her abilities as a person.

## Chapter Five

### Discussion

The aim of this research was to explore individual experiences of recovery from work-related trauma within an ecological framework. Specifically, the impact of the worker's compensation system on their experience of the recovery process was explored. The second aim of the study was to explore differences in the recovery experiences of those who sustained physical and psychological injuries versus those who sustained psychological injuries only.

Overall, the findings of this study are supportive of the work of Harvey (1996) and others (e.g., Saavitrne et al., 1998; Young & Ensing, 1999) that highlight the importance of participant perceptions and the role of the psycho-social environment in which the trauma took place. Viewing recovery from work-related trauma within an ecological framework facilitated a better understanding of the overall recovery process and highlighted a range of concepts for further exploration.

The range of issues generated by this study suggests that a view of recovery as solely a therapy outcome or symptom reduction is not sufficient. Recovery from work-related trauma needs to be considered within the context of each individual's unique experience. An individual's recovery environment is comprised of a number of nested systems (Bronfenbrenner, 1977). Within this context, these include individual's personal resources and perceptions, their interactions with the social environment including family, employer, coworkers and professional support and the larger umbrella of the worker's compensation system. The individual's perception of his/her interactions with the components of these systems will profoundly impact the individual by either fostering or impeding the recovery process. Thus, a positive recovery outcome will depend on the degree to which the individual's perceptions of the interactions of the systems are positive and whether the interactions with these systems facilitate an "ecological fit" between the individual and their recovery context (Harvey, 1996). This study revealed a number of key concepts in the participant's experiences of recovery from work-related trauma.

The concepts revealed in this study are discussed in terms of the nested systems experienced in the recovery environment. Firstly, the influence of the worker's



compensation system is discussed as the framework in which the interactions occurred. the concepts are then grouped in successive levels moving to social support systems and downward to the individual's personal systems. The interaction of these systems and the effect of physical and psychological versus physical trauma is also discussed.

### The Influence of the Worker's Compensation System

Participant's interactions with the worker's compensation system profoundly influence their recovery experiences. An individual who lodges a worker's compensation claim is immediately placed within an established framework. This framework provides assistance to the individual through access to health professionals and financial aid. However, the system also clearly dictates a number of expectations of the individual. These include requirements for attendance at certain appointments, expectations of participation in vocational rehabilitation and consequences for non-compliance. As a contextual framework, the worker's compensation system was experienced both uniquely and with shared experiences by the participants. The system was found to both impinge and facilitate recovery through the interactions that the individual experienced within the framework of this recovery environment. The interactions the individual experienced within the system affected their experience of the recovery process. Moreover, the worker's compensation system as a contextual factor mediated or influenced the individual's perception of their interactions with the recovery environment and therefore impacted on their recovery experiences.

The individual's perception of their interactions with the system appears to be a key issue in recovery as opposed to what may or may not be the reality of the interactions. As previously noted by Lazarus and Folkman (1984), it is not the actual amount of social support that a person receives that is important, it is their perception of the amount of social support. The idea of perceived significance was supported by this study, the participant's perceptions were influenced by the worker's compensation system.

For the participants, being in the worker's compensation system had far reaching consequences. The system's influence permeated the individual's recovery environment

as it shaped how they perceived their interactions with others. This influence may be viewed as two main concepts, legitimacy of the injury and personal control.

### Legitimacy of Injury

The participants in the study expressed a keen awareness of the stigma associated with being in the worker's compensation system. They described feeling that they were not believed, particularly as PTSD is not a visible injury. Having the perception that others did not view their injury as legitimate impacted on their perception of themselves and their perception of the intentions of the individuals they interacted with. Participants reported resulting feelings of anger and helplessness and viewed the system and those in it as hostile and obstructive.

### Personal Control

The loss of control experienced in trauma results in a desire to preserve control (Joseph & Williams, 1993). Thus, individuals often attempt to exercise control over their environment by altering it (Solomon et al., 1988). However, being in the worker's compensation system affected the participant's ability to exercise personal control over their situation. The system constrained their ability to make certain choices within the recovery process. For example, individuals in the system are required to participate in vocational rehabilitation and attempt to return to the workforce. The individual can refuse to participate, however there are negative financial consequences to this decision. For some of the participants the original loss of control they experienced during the trauma paled into insignificance by the repeated secondary traumatisations they experienced within the system. The participants believed they were unable to choose what was best for them and felt others in the system were coercing them to behave in certain ways. Not being able to regain a sense of control had a negative impact on participant's self-esteem and ability to recover.

### Social Support Systems

Consistent with the work of Flannery (1990), participants identified different types of social support. As suggested by Lyons (1991) different types of support were

valued from different sources. Moreover, participants identified a need for different types of support at different stages of the recovery process. Support from the employer and family was identified as essential in the early stages whereas support from co-workers and friends was identified as important after the initial shock of the trauma.

### Employer Support

The perceived support of the participant's employer was found to be a significant factor in the recovery process. The participants identified the need for the employer to display support immediately following the trauma. Positive employer support was perceived as practical and tangible such as continuing to pay wages, a letter of commendation or flexibility in the return to work process. Flannery (1990) describes this type of support as instrumental support, he notes the aim of this type of support is to help the individual problem solve and it is most useful with specific problems. Negative employer interactions were those perceived as passive or uninterested such as a lack of communication or attention or lack of involvement in the rehabilitation process.

Employer support within the system is enmeshed with the concept of legitimacy or acknowledgment of the individual. Due to the legalities of the system a situation is created in which the individual had to repeatedly present their injuries to a variety of health professionals. This can be particularly difficult if the injury is psychological and cannot be readily viewed. Individuals are left facing two of the most stigmatised issues in society, mental illness and a worker's compensation claim. Being believed or validated by the employer is of particular importance. The employer may ultimately be held legally accountable for the injury, thus their support of an injured worker can go a long way to quelling skepticism in regards to the legitimacy of an individual's worker's compensation claim.

### Family Support

Support from family was viewed as necessary particularly in the early stages of recovery. Consistent with the work of Orford (1992), this type of support was more emotional than practical. Flannery (1990) notes the importance of sharing feelings with others and being listened to. Like support from the employer and all other groups within the individual's environment the underlying important ingredients are validation and recognition of the legitimacy of their injury. Those individuals in the study who felt they

were believed and listened to without judgment perceived the social support they received as positive and helpful. Perceptions of negative support from family members contained some of the elements described by Orford, in particular, emotional over involvement by family members. Participant's described this as others attempting to 'rescue' or over assist them in the recovery process. Those who felt criticised or judged alienated themselves from those they were close to and reported that they believed their family was unable to help or understand them in the process. Orford describes this as the notion of acceptance versus rejection and suggests it is an integral component of social support. The participant's perception of the skepticism surrounding their injuries highlights the importance of this concept.

#### Friends

The participants identified the importance of non-judgmental listening and acceptance from those outside of the immediate family circle. Family support was viewed as emotional acceptance. However, a number of participants suggested that the closeness of partners could also be a barrier due to the secondary impact of the trauma on the family system. As they moved through the recovery process they expressed a need to gain support from others outside of the family circle. Thus, as suggested by Orford (1992) different types of social support were valued at different stages of the recovery process.

#### CoWorkers

Participants identified coworkers as a distinct group from which social support was needed. The role of coworkers was different from that of the employer and different from that of friends. Coworker's support was identified as important following the initial phase of the trauma. Participant's experiences suggest that any level of contact following the trauma was viewed as supportive, particularly if the coworker made contact prior to the injured party returning to the workplace. As coworkers are part of the workplace environment and its culture the main function of support from this group was validation, this was identified as vital in order for the individual to be able to return to the workplace.

#### Professional Support

The role of professionals particularly the medical profession was seen as providing information, validation and reassurance. The literature suggests that this is informational support, consistent with the research findings this type of support is viewed

as acceptable and helpful when given by professionals (Lyons, 1991). Negative perceptions again related to the issue of legitimacy. Participants reported that they were not believed and that they did not get treatment as an individual with individual problems. This was the same for mental health practitioners such as psychologists and psychiatrists. The individual's unique context was not validated. Although, at one level, receiving 'a label' was reassuring, the approach to treating this did not account for the person's environment or other factors that contribute and exacerbate the problem. The individual needed to be seen as part of a system, a family, a workplace, a friendship network and an individual. Positive support was seen as non-judgmental, reassuring and non-subjective.

### Vocational Rehabilitation

Participants identified the actual process of vocational rehabilitation as helpful. However, a number of limitations in the vocational rehabilitation provider's ability to achieve the vocational aims were also identified. The structured nature of the return to work process was viewed as helpful. By following a structured programme of returning to work participants were able to readjust to the workplace. This assisted by allowing participants to feel more in control of the pace of their return to work and recovery. Thereby assisting in the process of regaining a perception of control (Solomon et al., 1988). Other positive benefits of vocational rehabilitation identified were providing assistance in career decisions and formulation of goals. The setting and achievement of personal goals was identified as an important aspect of the recovery process. Thus, vocational rehabilitation's function was viewed as assisting with problem solving and therefore providing practical, tangible support (Flannery, 1990).

Vocational rehabilitation and the return to work process had some negative influences on participant's recovery processes. Return to work programmes allows an individual to gradually return to the workplace by incrementally increasing the hours and days they undertake at work. The objective of this is to allow a gradual, controlled reintegration into the workplace. However, moving too slowly through this process resulted in negative consequences. Being unable to display competence upon return to the workplace resulted in feelings of demoralisation and the disruption to the organisational environment caused by an individual being present but not in a full capacity left the

worker believing they were a burden to their coworkers and unproductive. Thus, disrupting the process of regaining a perception of control.

The model outlined by Jacobson (1996) received some support from this study. He proposed emotional support would be most suitable initially, followed by informational support and material support. Participants in this study reported needing emotional support initially from family then informational support from professionals however, material or tangible support was viewed as important throughout the process. This may be due to the specific context of the workplace in which the trauma occurred. Therefore, the individual required validation from the employer as an immediate and influential source.

### The Individual's Personal Systems

Each individual faces recovery from trauma with their own unique set of experiences, memories and coping strategies. The individual's appraisal of their abilities and coping strategies influence their interactions with family, friends, coworkers, health professionals and others in the system, these interactions are transactional and bidirectional. The interactions with all of the mentioned parties and the system will conversely also influence the individual's appraisal of their abilities and coping strategies. The findings of this study suggest that the individual's coping style and cognitive appraisal of their situation can be grouped into two main categories; active coping or passive coping.

#### Active Coping Style

Participants and key informants identified a number of elements that facilitate the recovery process. Taking an active approach to recovery was seen as important in regaining a sense of personal control over their situation. An active approach consisted of taking responsibility for the recovery process personally and therefore seeking out the necessary assistance. It is important to note that the coping is context dependent. Taking responsibility for recovery included the importance of being able to make choices without fear of censure, no matter how small the decision. In this manner a sense of personal control was rebuilt. Lazarus and Folkman (1984) note the importance of utilising problem solving strategies such as these in effective coping.

It is of note that as suggested by Janoff-Bulman (1985) and Solomon et al. (1988) a sense of personal control was also reestablished by attempts to control the environment, such as becoming more security conscious to minimise the risk of reoccurrence.

Cognitively, it appeared that viewing recovery as a challenge and actively setting tasks or goals to achieve facilitated the recovery process. Lazarus and Folkman (1984) state that individuals who engage in challenge appraisals are more able to utilise coping resources and are more likely to experience positive emotions. Viewing recovery as a challenge or series of challenges assisted by allowing participants to view smaller successes and therefore contributed to self-belief in their ability to recover.

An interesting finding was the use of removal and distraction strategies as a method of coping. Participants did not see this as avoidance but rather a positive strategy to distract from the consistent intrusive thoughts regarding the incident. Participants identified a need to remove themselves both physically and emotionally from the trauma and distract constant thoughts in order to minimise the pressure they experienced. This was seen as time to disconnect prior to beginning to attempt to reconnect to their environment in the recovery process.

This finding is consistent with the suggestion of Shontz (1984). He reported that withdrawal following trauma could be an adaptive strategy, by allowing the individual to retreat to a sense of security. As recovery progresses the individual shifts back and forth between retreating (such as removal or distraction) and confronting their fears. As they progress the need to retreat lessens.

Self-responsibility for recovery was clearly distinguished from responsibility for the trauma. This distinction was important in order to avoid self-blame and to facilitate reconciling the lack of control experienced in the traumatic situation. The distinction between characterological self-blame and behavioural self-blame identified by Janoff-Bulman (1985) was apparent in participant's accounts. Some identified initial behavioural self-blame, for example self-blame for the loss of money or self-blame for a lack of security procedures. However, as Janoff-Bulman suggests this can give way to a more balanced view. Participants distinguished this from the responsibility for the attack and thus moved away from negative self-appraisal and characterological self-blame.

### Passive Coping Style

Assuming a passive role in the recovery process appears to be influenced by interactions with the worker's compensation system. Participants identified the importance of taking responsibility for their own recovery, the alternative was to accept a passive 'sick role' viewing the situation as beyond their control and themselves as helpless and passive. This approach is somewhat similar to the learned helplessness response in PTSD patients described by Joseph et al. (1999).

Lazarus and Folkman (1984) suggest that the way in which an individual chooses to cope will depend on what resources are available to them. The impact of the worker's compensation system may be to affect the individual's ability to regulate their coping approaches in order to find the correct balance. Participation in the worker's compensation system may contribute to this by disrupting the role of internal resources and natural resources in the individual's recovery environment.

As discussed, the requirement to repeatedly exhibit their level of impairment can impact on the individual's focus. Rather than being focused on recovery the individual's focus is maintained on their symptoms and as a result a passive role is encouraged.

### Interaction of Personal Resources and the Recovery Environment

The influence of the worker's compensation system permeates all of the nested systems within an individual's recovery environment. Viewing recovery from a systems perspective highlights the constant transaction that occurs between the individual and their recovery environment and the impact this has on the recovery process. The impact of this may be extremely positive. If the individual's interactions within the system and their recovery environment are such that the individual views themselves as strong and competent, their family as supportive and recovery as not only possible but a challenge a number of positive outcomes beyond merely coping emerge.

Psychological growth may be the result of the individual's recovery. Participant's experiences in this study were congruous with the three main domains of change suggested by Calhoun and Tedeschi (1998). These are changes in self-perception, a change in relationship with others and a change in philosophy or outlook on life. The individuals in this study mainly described a change in focus or a reprioritising of major



life goals. Participants identified a greater focus on quality of life and increased importance of their family. Conversely, they identified a decrease in priority of money, status and career goals. Calhoun and Tedeschi note a change in priority to be a primary indication of psychological growth.

### Physical/ Psychological Versus Psychological Trauma

The findings from this study suggest that victims of physical/psychological injury versus those who have only sustained a psychological injury only do perceive differences in their recovery experience.

#### Psychological Injury

Schneider (1994) found that bodily injury is perceived as more serious than psychological injury. The main issue identified by the participants was a lack of recognition of the injury, this in turn created doubt as to whether others in the system viewed their injury as legitimate. Recognition of the injury was identified as being crucial particularly in the early stages of recovery and by key parties such as the employer.

Those with a psychological injury expressed that the lack of visible evidence of impact meant that they believed they were marginalised and the impact of the trauma failed to be recognised and therefore was not addressed. If it was addressed they believed it was done so too late and in a limited and unsatisfactory manner. The impact of this was a delay in appropriate treatment and moreover the perception that they somehow do not have a right to assistance. The lack of recognition combined with a perceived stigmatisation or prejudice had a significant impact on self-esteem and the individual's perception of control and their perception of their ability to recover.

A lack of recognition as to the psychological impact of the trauma had significant consequences for the participants. Not being believed or at the very least perceiving this to be the case resulted in the individual choosing to become increasingly isolated. Isolation from others especially friends and coworkers meant that the individual did not seek the social support that they needed. Becoming increasingly isolated results in the adoption of a passive approach to recovery, focusing on symptoms and appraising the situation as beyond personal control.

### Physical/Psychological Injury

Participants with physical/psychological injury also identified recognition of psychological injury as a significant problem in recovery. However, this was viewed differently from those who sustained a psychological injury only. Participants with a physical/psychological injury noted that a lack of recognition of the psychological trauma occurred by omission as during their treatment they perceived that the majority of the focus was placed on their physical injuries. This medical 'blind spot' has been previously noted in the literature. The work of Green et al. (1993) discussed earlier stated that in a sample of motor vehicle accident victims of which one third developed PTSD, not one person was diagnosed or offered psychological intervention. Those with physical injuries noted this dichotomous treatment resulted in feelings of anger at the lack of support that they received.

The physical trauma sustained was noted as impacting on the psychological recovery process. The physical trauma also impacted on the psychological trauma. The physical scars or pain served as a constant, tangible reminder of the trauma, triggering a fresh bout of anger when faced with photographs, mirrors, scars or other reminders on a daily basis. This was also affected by the reaction of others to the physical scars. Other's reactions of disgust or shock resulted in shame and anger at the traumas occurrence and further damaged the individual's sense of personal control.

However, it is of note that the physical healing process provided a framework upon which the individual could mark or attempt to follow with the psychological healing process. This occurred by the physical healing providing a structure in what appeared to be a chaotic and unrecognised process, as the physical scars healed the individual could see progress and subsequently reported an improvement in psychological symptoms.

## Chapter Six:

### Implications

Viewing recovery from work-related trauma from an ecological systems perspective has a number of implications for psychological practice. Understanding trauma recovery within an ecological perspective highlights the complex nature of trauma and recovery. This should be taken into account in psychological treatment. In order to obtain a fuller picture of a client's situation a comprehensive ecological assessment is necessary. This will include a review of the individual's personal resources, social support systems, interactions with community systems and the influence of being within the worker's compensation system. An ecological assessment would also explore the individual's perception of their environment and would review each of the nested systems within which the individual interacts.

The effectiveness of any recovery resource will depend on its appropriateness to the internal and external demands of the individual's own unique situation (Lazarus & Folkman, 1984). Clinicians need to be able to view and assess the whole picture. The individual has experienced a multifaceted, unique and deeply personal trauma and therefore will experience a unique multifaceted and deeply personal recovery. Viewing the larger context of trauma means changing the traditional view of clinical treatment. A reduction of what are defined as clinical symptoms is not sufficient for recovery. A reduction of what the client states as distressing and a return to functioning in a manner that the client (not the psychologist) finds acceptable should be the goal of treatment. This needs to include a wide view of the individual's situation or context as part of the problem and part of the solution.

Understanding the process of recovery and the role of naturally occurring supports and impacting factors is vital in attempting to assist individuals who have experienced trauma. With a clear understanding of the helpful and unhelpful factors that impact on this process, mental health professionals can aim to enhance the natural supports and other resources assisting the client and minimise the negative issues. This may prove imperative in obtaining a well-rounded individually focused treatment plan for individuals with PTSD.

The disempowerment experienced by participants due to their perception of their psychological injuries not being validated or legitimised is a key issue. This finding highlights the importance of psychological injuries being recognised and legitimised within the worker's compensation system and in the individual's larger recovery environment. Natural supports need to not only be identified but also educated as to appropriate support and the importance of recognising and validating psychological injury. This includes educating employers, professionals, family members and those in the system in order to overcome this barrier.

Beliefs and perceptions are changeable and can be modified. This is the key area in which mental health professionals can positively influence the recovery process. On a wider societal level the psychologist's challenge is to intervene in order to begin to destigmatise the issues surrounding psychological trauma. Harvey (1996) notes that community interventions can foster resilience in an individual. Education and initiatives to enhance community acceptance of work-related trauma and information as to the recovery process can assist in providing a community system that fosters positive coping and resilience in individuals who experience work-related trauma.

### Limitations and Directions for Future Research

Viewing recovery from an ecological perspective enhances our ability to assist with work-related trauma by adding a different perspective. However, there are a number of methodological limitations that need to be noted when interpreting the results of this study. Firstly, due to time and resource constraints it was not possible to interview the participants on more than one occasion. This would have enhanced the validity of the data obtained by allowing a checking of interpretations. Secondly, a more collaborative approach through multiple interviews or working with co-investigators may have been useful in constraining potential bias and further clarifying key issues.

This type of research relies on the participant's ability to recall their experiences. Their memory of their recovery experience may change over time. It would therefore be useful for future research to look at the process as it unfolds, and record experiences as they occur.

It would also be beneficial for future research to gain perspectives from a variety of different sources in the system, such as the doctors, employers, coworkers, psychologists and insurers. A direction for future research may also be to look at a broader range of individuals in the worker's compensation system, such as those with physical injury claims and the recovery environment of these individuals. By utilising an ecological framework and consulting with individuals who have experienced work-related trauma and those in their recovery environment, mental health professionals can gain a greater understanding of the influences surrounding the individual and a more holistic approach to assistance can be developed.

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Appendix A:  
Interview Schedule: Recovery from Trauma

[1] Theme Generating: Their Experience, Helpful/Non Helpful.

[2] Literature/Secondary Participant Themes

- Extent of physical injury
- Environmental and contextual factors
- Cognitive appraisal
- Coping style
- Positive adjustment

[3] Importance of the Generated Factors

Introductory Questions

- Current Status
- Occupation
- Family situation
- Physical functioning

Theme Generating: Participant

- I am interested in talking to people about their recovery from work-related trauma. Would you tell me about your recovery experiences?
- Do you believe you are recovered?
- What was the most helpful in aiding your recovery? What else?
- What was the least helpful?
- What was the worst part about your recovery experience and what was the best?
- What experiences helped/set back your recovery outside of formal intervention
- What / whom have you lost/gained since the incident/accident
- Negative outcomes positive outcomes
- What intervention would you have liked
- What did others do that hindered your recovery?
- Do you think there is anything you did that hindered your recovery?
- How did this experience affect you overall - and what compounded these feelings?

Literature/Secondary Participant Themes

*Extent of Physical Injury*

- During your recovery how much attention was focused on your physical injury?

- Was there any difference in assistance provided for your physical injuries as opposed to your psychological difficulties?

### *Environmental and Contextual Factors*

- Did you access any groups or services in the community?
  - helpful/unhelpful?
  - How
  - What did you gain/lose from this?
- What community groups do you belong to?
  - How important was this group in your recovery?
- Do you belong to any religious groups, what was their significance in your recovery?
- What was your experience of :
  - The Workers Compensation System
  - Vocational Rehabilitation
  - The Medical Profession
  - Mental Health Services
- What do you believe your coworkers thought about you being on Workers Compensation
- Was your employer and coworkers supportive, How?
- What was your experience of the insurance company?
- Did you face any prejudice in the community?
  - From where?
  - What was it like?
- Perceived support and belief by coworkers and boss – (factor of stigma in Workers compensation, how did that affect your recovery?)

What concrete resources were available to you?

### *Cognitive Appraisal*

- What is your opinion of individuals on workers compensation?
- What is your opinion of individuals who have a mental illness
- Has the way you view the trauma changed over time?
- How did you mentally deal with the trauma?
- How do you make sense of your experience?
- Why do you think this happened to you?
- How do you reconcile the lack of control over the situation?
- Control (primary, secondary, illusory, interpretive, cognitive and behavioural)

### *Coping Style*

- What efforts did you make to manage after the event?
- How do you tackle a stressful events?
- How did you cope emotionally?

- How did you cope with the difficulties you faced after the incident?
- Did you relocate after the incident and for what reason?
- What did you do to cope with the situation? What coping resources did you utilise?  
And When? how much?

(E.g health, energy, positive beliefs, problem solving skills, social skills, social support, material resources)

(locus of control - external versus internal)

### *Positive Adjustment*

- What do you do now that you didn't before?
- Have you experienced any positive outcomes from your experience
- Psychological growth

### *Social Support*

- What Social support did you have?
- What was of comfort to you?
  - how, why, when?
- What was of no comfort?
- What assistance did you receive? From whom?
  - how helpful was this assistance?
- What would have been more helpful?
- Who was the best source of support?
- What community-based services did you access?
- How helpful were these services
- Who was the main support?
- What was the response of
  - a) your partner
  - b) family
  - c) children
  - d) friends
  - e) co-workers
  - f) boss
- How effective and what was effective
- What would your preferred level of contact been? (and from whom)
- What was your experience of?
  - Critical Incident Debriefing, Vocational Rehabilitation, Medical Profession, psychologists, psychiatrists, employers Insurers WorkCover
- Out of these key system parties and the process/ experience of each - which were helpful?
- What was valuable?
- Short term - Medium term - Long term
- What was damaging?

- Short term - Medium term - Long term
- Retrospectively what and how would you change the intervention offered to you post trauma – what else would you change e.g. – social support, getting in touch with support groups, information and education

<b>General Questions</b>
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- If you could go back and recover from the incident again?
  - (a) What would you do differently?
  - (b) What would be ideal in terms of intervention and support
- How did people react to you when they knew you were experiencing psychological difficulties?
- Is there anything you would like to add?

Appendix B  
General Information and Informed Consent

<b>GENERAL INFORMATION AND INFORMED CONSENT</b>
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My name is Sally Edmondson and I am a clinical psychology masters student at Edith Cowan University. I would like to invite you to participate in my research project. This project in aims to investigate the recovery experiences of individuals who have experienced a traumatic event at their workplace. This is being undertaken in order to help discover what are the most important resources to help individuals recover from work-related trauma.

This research conforms to the guidelines produced by the Ethics Committee of the School of Psychology at Edith Cowan University.

The research will require you to give the investigator permission to review your vocational rehabilitation file for information on your recovery experience (for example, medical progress reports) and also to participate in an interview with the researcher.

The interview will be tape recorded and will consist of a short questionnaire on your current symptoms (if any) in relation to your experience and a discussion of your experience of recovery. In particular what you believed helped you and what was not helpful. Please note that you are free to refuse permission to answer questions at any stage of the research. The interview is estimated to take approximately 60 to 90 minutes. With your permission the tape will be transcribed for ease of analysis only. The research data gathered for the study may be published and the master's thesis is a public document. However, I will ensure that no identifiable information is contained within the document.

Please be assured that any information you provide will be held in the strictest confidence by the researcher. Your name will not be reported along with your responses or connected to the interview in anyway. If you want me to send you a copy of the results, please call me on 0413 380 312.

Please understand that your participation in this research is entirely voluntary and you are free to withdraw your consent at any time during the study without penalty, and remove any data that you may have contributed.

Any questions concerning the project can be directed to Ms Sally Edmondson (Principal Investigator) on 9371 2586 or 0413 380 312 or the project supervisors Dr Chris Sonn (9400 5105) or Dr Neil Drew (9400 5541). Please retain this information sheet.

I \_\_\_\_\_ have read the information above and any questions I have asked have been answered to my satisfaction. I agree to participate in this activity, realising that I may withdraw at any time. I agree that the research data gathered for the study may be published provided I am not identifiable.

\_\_\_\_\_  
**Participant** **Date**

\_\_\_\_\_  
**Investigator** **Date**



Appendix C  
Document Contact Form

File:

Date Coded:

Name or Description of Document:	Written by:
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Salient Points	Theme/Aspects	Comments/Notes

Appendix D  
File Summary Form

File :  
Date coded:

Document Type	Progress Report	Medical Report	Phone Call	File Note	C/Psych Report	Other	Total
Issues (+)							
Issues (-)							

Notes/ Comments